



Dr. Robert F Kidd, MD newsletter archive
For neural therapy and advanced healing



Volume 1, No. 1, April 2006

NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleague:

Welcome aboard, and thank you for your interest in neural therapy.

In my experience, physicians in the English-speaking world of medicine who have been exposed to neural therapy are fascinated by it. However, this fascination can quickly turn to frustration when they begin to look for written information about how it works, how it is applied and what to do when it does not work.

My book, *Neural Therapy: Applied Neurophysiology and Other Topics*, has been an effort to remedy this situation. As far as I know, it is the only English-language textbook on the subject since the translation of the German text by Peter Dosch 25 years ago. (His son, Mathias, has since published a reference book, *Atlas of Neural Therapy: With Local Anesthetics*.) However, much more is needed than textbooks.

In my opinion, neural therapy builds on applied neurophysiology, but it takes experience to develop that "sixth sense" of where the interference fields might be found. Experience also tells us when to look for confounding factors - factors that might be limiting the effectiveness of treatment.

"Only a fool learns by experience; a wise man learns by the experience of others"... or so the saying goes. My hope is that this newsletter will be a resource allowing you to learn from the neural therapy experiences of others - and share your own experiences.

My plan is to offer a case history, a clinical pearl or an observation with each issue. Some basic knowledge of neural therapy will be assumed. I may discuss more advanced topics later depending on readers' response. You are invited to contribute, question and challenge. (I reserve the right to edit).

So here goes:

What causes mystery pain in a tooth? Dental pain can be a difficult diagnostic problem. There are times when a patient will have a most unpleasant toothache for which the dentist can find no cause. In desperation, the dentist will sometimes perform a root canal procedure in the hope of obtaining relief.

If the root canal fails, an adjacent tooth is sometimes judged to be the culprit. If that tooth also is treated endodontically and the pain persists, extraction of a tooth or teeth is often tried. But frequently the patient is left with the same pain.

On several occasions, I have seen patients who have endured three successive root canals on adjacent teeth followed by three extractions - to no effect. The teeth are almost always upper premolars and molars, although "mystery pain" may also occur in lower teeth.



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Simons and Travell's textbook, *Myofascial Pain and Dysfunction: The Trigger Point Manual*, describes referred pain to teeth from trigger points in the temporalis, masseter and digastric muscles.

These muscles share with the teeth innervation by autonomic nervous system fibers synapsing in regional ganglia: the sphenopalatine ganglia for the temporalis and upper masseter muscles and the upper teeth and the inframandibular ganglia for the digastric and lower masseter muscles and the lower teeth.

Permanent cure of these "mystery" pains is almost always achieved by one injection of procaine ½% into the appropriate ganglia. The techniques are described in detail in *Neural Therapy: Applied Neurophysiology and Other Topics*.

An alternative and equally effective treatment is by way of an electro-physical device, the TensCam (available from Charles Crosby, DO, of Orlando, Florida at 407-823-9502).

If you have neural therapy cases you would like to share - or if there are specific topics you would like me to address in future issues of this newsletter - please e-mail me at drkidd@neuraltherapybook.com.

Sincerely,

Robert F. Kidd, MD, CM

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Dear Colleague:

This letter is written soon after returning from the American Association of Orthopaedic Medicine's annual meeting in Washington, DC. The meeting was largely devoted to *prolotherapy*, a method of strengthening ligaments and joint capsules by injecting irritant solutions, such as dextrose, into weakened connective tissue.

As it happens, one of the first patients I saw in my office this week was a 49-year-old woman with *iliolumbar syndrome*, a back pain centering in the iliolumbar ligament and radiating into the hip region. She had had this for many years and manipulation of the pelvic ring and lumbar spine had provided only temporary relief. The pelvic ring seemed unstable and I accordingly began prolotherapy about three months ago -- injecting the iliolumbar, posterior sacroiliac and interosseous ligaments bilaterally with a 12-1/2% dextrose solution.

My practice is to repeat the injections every two weeks. After two sessions, the woman was experiencing considerable pain relief; and after the third session, I felt she was "home free" and would probably need no further prolotherapy. Accordingly, the next appointment was scheduled for six weeks later with the expectation that it would be a simple follow-up visit.

However, I was disappointed to hear that soon after her last visit, the pain had returned as strongly as ever. In fact, it seemed to be worse at night; her sleep was being badly disturbed. In my 28 years' experience, patients' response to prolotherapy has usually been a steady, gradual improvement. A sudden relapse without triggering trauma raised a red flag and made me think something else was going on -- perhaps an interference field.

Could an interference field be causing the pain?

The most common non-mechanical location of an interference field in the low back is the third lumbar sympathetic ganglion, but autonomic response testing revealed nothing. Abdominal and pelvic viscera were unlikely candidates, as the patient had good gastrointestinal and genitourinary function and was otherwise healthy. She had no surgical scars and no history of recent dental work. However, the patient complained that a dental bridge in her ipsilateral upper molars was chronically uncomfortable and that the irritation had recently worsened.

Autonomic response testing indicated an interference field at the site of a previously extracted upper wisdom tooth. Whether the remaining second molar, anchoring the problematic bridge, was irritating the wisdom tooth space was uncertain. However, injection of the wisdom tooth space with procaine 1/2% followed by an intravenous bolus gave immediate relief.

This patient's long-term prognosis is still uncertain. She may have had an interference field in the wisdom tooth space since extraction in her 20s, in which case repeat procaine injections into the tooth space may be all that is required to cure her iliolumbar syndrome. Another possibility is that the space is irritated by a badly fitting bridge. If so, dental work on the bridge may be necessary. A third option might be chronic infection or even a cavitation in the wisdom tooth space. Injection of



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homeopathics or dental surgery would be required in that case.

The point of this case history is not just that dental interference fields can cause trouble almost anywhere in the body. A more subtle lesson is that interference fields can be an underlying or "background" factor complicating a legitimate diagnosis made on mechanical or other grounds. This patient definitely had an iliolumbar ligament syndrome and also had underlying low-back instability. However, treating the abnormal mechanics was not enough in her case. Resetting the neurological (or energetic) controls is often needed when response to the usual treatments is unusual.

Sincerely,

Robert F. Kidd, MD, CM

Want more details on dental aspects of Neural Therapy?
You'll find more information on dental aspects of neural therapy in chapter 7 of my book, *Neural Therapy: Applied Neurophysiology and Other Topics*, available at www.neuraltherapybook.com .



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Dear Colleague:

In this issue, I'd like to discuss *piriformis syndrome*, one of the more interesting conditions caused by spasm of a specific muscle. This syndrome is intriguing, not only from a functional standpoint, but also from an anatomical perspective. The piriformis muscle can cause pain when in spasm, like any other muscle. Things get complicated by its relationship to the sciatic nerve, which runs close to - or even through - the piriformis muscle and can be irritated or entrapped by muscle spasm.

Is it a herniated disc or piriformis syndrome?

Sciatic nerve entrapment can mimic lumbar disc herniation, complete with motor and sensory neurological deficits. The piriformis muscle should be examined in all cases of failed back surgery or, even better, before lumbar disc surgery is contemplated.

The piriformis muscle originates on the anterior aspect of the lower sacrum, crosses the sacroiliac joint and, through its tendon, attaches to the posterior aspect of the greater trochanter of the hip. Its mechanical importance arises from it being both an external rotator of the hip and a stabilizer of the sacroiliac joint.

The piriformis is particularly important during the gait cycle as it helps guide the lower sacrum through a complex rocking and rolling of the sacrum on moving axes between the innominate bones. The intricacy of pelvic ring mechanics is awe-inspiring (See Dr. Wolf Schamberger's excellent coverage of this topic in his book, *The Malalignment Syndrome: Implications for Medicine and Sport*.

<http://www.malalignmentsyndrome.com/theBook.htm>)

It is therefore hardly surprising that things can go wrong with the piriformis.

Of all the muscles involved in moving the legs and stabilizing the pelvis, the piriformis seems to be one of the muscles that decompensates more commonly, perhaps because so much is asked of it.

The piriformis muscle is a "postural" muscle (according to Janda). It therefore tends to shorten when overloaded, becomes tighter, and develops trigger points. Piriformis muscle trigger points refer pain in specific patterns (See Travell and Simons *"Myofascial Pain and Dysfunction - The Trigger Point Manual."*)

http://www.amazon.com/gp/product/0683307711/sr=8-1/qid=1151067841/ref=pd_bbs_1/103-1899142-6805419?%5Fencoding=UTF8

How is piriformis muscle spasm treated?

There are a number of ways of treating piriformis muscle spasm: by manipulation, by digital massage of the muscle belly through the rectum, by spray and stretch technique or by various injection techniques. Piriformis muscle spasm generally responds well to treatment, leaving a gratified patient and a satisfied physician.

However, on occasion, the piriformis muscle can be unusually irritable and unresponsive to treatment. When this occurs, one must look beyond the muscle itself and ask why the muscle is behaving in this way.



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Could an interference field be involved?

Other mechanical stresses on the pelvis, such as innominate or sacral shears, or on the lower extremity, such as fibular, ankle or feet somatic dysfunction, should be searched for and treated. However, if the tight piriformis persists, it may be that the sympathetic tone of the muscle, or even of the whole region, is increased. When this occurs, an interference field in the ipsilateral lumbar sympathetic ganglia is likely present.

Another clue pointing to an interference field “behind” the piriformis syndrome is a pain pattern extending beyond the referral pattern from piriformis trigger points and not explainable by sciatic nerve entrapment. Pain felt above the iliac crest should make one particularly suspicious.

Where does Neural Therapy come in?

Treatment of the interference field in the lumbar sympathetic ganglia is by injection of procaine as outlined on page 188 of my book, *Neural Therapy: Applied Neurophysiology and Other Topics*.

<http://www.rfkidd.com/booksite/order.html> Alternatively, treatment with a TensCam device (page 65 of the same book) is fast, safe and probably equally effective.

Interference fields in regional autonomic ganglia should always be considered when an interference field (or somatic dysfunction) is particularly painful or difficult to treat.

Autonomic ganglion interference fields seem to develop when more than one interference field is present in the region the ganglion innervates or when the afferent neurological signals are particularly intense.



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Dear Colleague:

Do any of your patients suffer from “funny” abdominal pain? This month I want to discuss an often-overlooked part of our anatomy- the umbilicus -and its potential importance in clinical medicine. Some of its properties are surprising, at least to me, and can be keys to an otherwise unexplainable pain syndrome.

Contemplating the navel

The umbilicus- OK, the “belly button” - is receiving more attention than ever before. Navel rings seem to be a fashion statement by a whole generation of young women. And in some circles, the navel is not just a belly button; it is an “inny” or an “outy”. One is supposed to be prettier than the other, but I forget which one.

My interest in the umbilicus is not entirely an idle one. This funny little scar is not just a reminder of an early stage of our lives. It is also energetically important and can be the source of an unusual abdominal pain syndrome - more about that later.

Beyond skin deep: The navel is an energy portal

In Oriental medicine, the umbilicus is considered one of the major energy portals into the body. The middle of the umbilicus is an important acupuncture point (Conception Vessel 8) and is considered a “forbidden point”, i.e., it should not be treated with a needle. There is also a school of acupuncture that uses a set of points around the umbilicus, much as ear acupuncturists use points in the external ear.

In autonomic response testing (See chapter 4 of my book, *Neural Therapy: Applied Neurophysiology and Other Topics* www.neuraltherapybook.com the sensitivity of the umbilicus to energy emitted from the palm of the hand is used to test the general responsiveness of the whole autonomic nervous system. Placing the palm of the open hand slightly above the umbilicus should, in a healthy person, trigger an autonomic response (a weakening of an indicator muscle).

Western medicine has shown little interest in the umbilicus, perhaps because it is considered a vestigial organ. Like the appendix, the umbilicus can cause problems under certain circumstances. But unlike the appendix, which can be a source of serious disease, the problems caused by the umbilicus are subtle and probably hardly ever diagnosed (outside of neural therapy circles).

The umbilicus can harbor an interference field

In my practice, I find perhaps two or three cases a year of an interference field in the umbilicus. The patient is nearly always female and has had many years of intermittent abdominal pain. The pain is usually crampy, diffuse and difficult to describe. In some cases, it is accompanied by nausea or diarrhea. Most patients with this condition have had extensive investigations, sometimes beginning in childhood.

Very little is found on physical examination. However, there is one characteristic finding that seems always to be present. When the examining hand approaches the umbilicus,



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the patient will register a peculiar apprehension and will often try to push the hand away. The reaction is similar to that of extreme ticklishness, but the feeling is not that of a tickle. The patient has trouble explaining why the umbilicus feels so vulnerable and may even be embarrassed by her own behavior.

Autonomic response testing will confirm that the umbilicus is an interference field. Treatment is injection of procaine into the skin surrounding the umbilicus. It is not necessary to infiltrate deep into the umbilicus.

Response is the same as that from treatment of any other interference field. Relief of pain may last a day, a week, a month or even longer. Repeat treatments are increasingly effective and eventually the pain relief is permanent.

I have seen one case of acquired interference field at the umbilicus in an elderly man with ascites. Presumably the increased abdominal pressure caused mechanical stress at the umbilicus. Backache resulted, and treatment of the interference field relieved the backache.

However, a permanent response did not occur until the ascites was treated and the pressure on the umbilicus was relieved.

I welcome your feedback on the umbilicus, especially if you are knowledgeable about Chinese medicine. And here's a reminder that I am always interested in your case reports, comments, questions and other contributions. With your permission, I will feature them in this newsletter and/or on www.neuraltherapybook.com. Please e-mail me at drkidd@neuraltherapybook.com.



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Dear Colleague:

Our neural therapy e-newsletter list is growing! If you're a newcomer, thanks for signing on. If you're an "old hand" at neural therapy, I encourage you to send your case presentations, as well as your comments and questions. A neural therapy journal is badly needed and until there is one, I would like to see this newsletter become a forum for us to share our neural therapy knowledge and experiences.

Getting to the bottom of things

This month I would like to discuss the pelvic floor, an area of our anatomy that is critical to the body's musculoskeletal balance and health, yet commonly neglected and poorly understood by many physicians. The pelvic floor may be neglected partly because its mechanics are subtle.

Patients with pelvic floor imbalances are usually unaware that a mechanical problem is present, even though they may have unexplained pain in the low back, coccyx or legs. And yes, neural therapy may be a key to unlocking some of the puzzles behind these pain conditions.

Coccydynia - A pain in the tailbone

The structure most likely to manifest musculoskeletal pain in this area is the coccyx. The grand Latin name for this painful condition is coccydynia or coccygodynia. Often coccydynia is triggered by direct trauma to the coccyx - but the puzzle is, why does the acute pain become chronic?

There are a number of possible reasons why acute coccydynia becomes chronic or why chronic coccydynia appears with no apparent cause. Most of these reasons have little to do with the coccyx itself. One way of looking at this question is to see that the coccyx is located more or less in the middle of the pelvic floor. Imbalances of the pelvic floor muscles will therefore put chronic strain on the sacro-coccygeal joint and make it irritable and painful.

In turn, muscle imbalances of the pelvic floor do not occur in isolation and are always associated with mechanical disturbance (somatic dysfunction) of the pelvic ring. Therefore, manipulation of the pelvis is often a part of coccydynia treatment.

Examining the pelvic floor

Mobility of the coccyx should be assessed directly by grasping it (through the rectum) between the index finger and the thumb. If moving the coccyx in one direction increases the pain, moving it in the opposite direction, and holding it there for a minute or so, will sometimes provide considerable relief. (A release or softening of the tissues is felt at a certain point.)

The pelvic floor muscles can also be examined directly by positioning the fully clothed patient supine with hips and knees flexed and feet on the examining table. The examining hand comes underneath the leg, around the buttock so that the second to



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fifth fingertips gently probe the pelvic floor muscles. With pelvic floor muscle imbalance, the right side is usually tighter than the left. Gently pushing the tighter side cephalad and holding it until a release is felt will often balance the pelvic floor.

Should you suspect an interference field?

How about non-mechanical disturbance in this region? What about interference fields? The pelvic floor itself (like the scalp) rarely harbors interference fields. Occasionally, one can be found in a Bartholin cyst (or its scar) or in the urethra. More common by far are interference fields in the anus and the pre-coccygeal ganglion.

Anus interference fields usually result from present or past local difficulties, e.g., fissures, fistulas, or painful hemorrhoids. Treatment is a ring of quaddles a couple of inches away from the anus, followed by a small intravenous bolus of dilute procaine.

Pre-coccygeal ganglion interference fields usually develop after trauma to the coccyx or in association with other interference fields in the pelvis or pelvic floor. They should be looked for especially in conjunction with anal interference fields. Treatment is by injection (see page 192 of *Neural Therapy: Applied Neurophysiology and Other Topics*) or by use of the TensCam device available from Charles Crosby, DO, of Orlando, Florida at 407-823-9502.

Pelvic floor interference fields may be silent locally and cause pain in the low back, legs, or even farther afield. They should be suspected particularly with inner-thigh pain or bilateral knee pain. And pelvic floor interference fields are almost certainly present when pelvic ring and leg mechanics are in perfect balance, yet pain persists.



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Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleague,

This month I'd like to take a break from the usual neural therapy case reports and clinical tips to report on a new book I have been reading. [The Integrative Action of the Autonomic Nervous System - Neurobiology of Homeostasis](#), by Wilfrid Jänig, was released in July by the Cambridge University Press.

Remembering the days of "low-tech" biological science

If you know me, you know I have long been a fan of "old" science - especially that from the first half of the twentieth century. Much of the biological sciences was explored with low-tech equipment, used relatively simple mathematics and was understandable to the average educated lay person, which would include most physicians.

I think of the classical neurophysiology of Pavlov, Sherrington, Brain, Head and Speransky, the nutritional science of Price, Page and Royal Lee and the biochemistry (and world view) of Revici. Of course, the Huneke brothers - who discovered neural therapy - were in this cohort, even though they were clinicians and not professional scientists.

It is a sad fact that much of this very fine basic science has never been applied to clinical medicine. The perennial cry of "more research!" is often an excuse to not truly examine the implications of discoveries already made. I think of the simple neurophysiological principles of temporal and spatial summation and their application to musculoskeletal pain - that there might be a number of converging "pain generators" responsible for a particular pain syndrome.

Neural therapy applies neurophysiology to medicine

Neural therapy is all about applying neurophysiological principles. So it is incumbent on the practitioner to know these principles and be up-to-date on new discoveries. And despite my fondness for "old" science, there is much of value "coming down the pipe" - and some of it actually modifies or even disproves older theories.

[The Integrative Action of the Autonomic Nervous System](#) is a big book. It is over 600 pages long, is richly illustrated with line drawings and has 80 pages of references. The author, Wilfrid Jänig, is one of the world's leading autonomic nervous system physiologists and has 45 years of research and hundreds of scientific papers and textbook chapters behind him.

Jänig's book is written for scientists. As the author states in his introduction, "This book is not intended to discuss the pathophysiology of the autonomic nervous system; however, it is the basis to understand pathophysiological changes of autonomic functions."

Gaining insight into the autonomic nervous system

There is much of value for clinicians in this book as well. Over the years, there have been some shifts in understanding of how the autonomic nervous system works, which have not yet been incorporated into medical thinking. Example: The concept



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of *sympathetic* and *parasympathetic* systems being separate systems, to a certain extent in opposition to each other.

A half-century of research has demonstrated that the only consistent difference between the two "systems" is their anatomical origin, i.e., the thoraco-lumbar spine for the sympathetic system, and the cranial and sacral regions for the parasympathetic system.

The former criteria of post-ganglionic neurons being cholinergic or adrenergic has too many exceptions to be useful. In fact, certain pelvic ganglia cannot be assigned to either the sympathetic or parasympathetic system and must simply be called autonomic.

For the neural therapist, this is a liberating concept. The challenge is simply to identify the local autonomic nervous dysfunction, then find and treat the interference field. It matters not whether the dysfunction is "sympathetic" or "parasympathetic" in origin.

Jänig sheds new light on peripheral ANS function

I must admit I have read only some portions of the book so far. Some sections are downright intimidating (at least for me) - especially those pertaining to central anatomy. However "pearls" pop up, particularly in the sections pertaining to peripheral autonomic nervous system function - the primary domain of the neural therapist. Among them are:

- 1) The concept of "sympathetic tone" being a determinant of peripheral vascular resistance, and therefore blood pressure, has been disproven (by Jänig).
- 2) Most target tissues are innervated by only one of the autonomic systems (the main exceptions being the heart and the urinary bladder).
- 3) Fast change in heart rate e.g., during changes of body position and emotional stress, are generated by parasympathetic neurons to the heart. Sustained increase of heart rate during exercise is generated by sympathetic neurons to the heart.
- 4) Neuropeptides have been found in many autonomic neurons that correlate with morphology, electrophysiology and anatomy. However, the function of most of these neuropeptides has not yet been elucidated and they may have nothing to do with neurotransmission.
- 5) Autonomic ganglia regulate the quantity of neural signals being transmitted to the tissues.
- 6) Single peripheral neurons show a wide array of discharge patterns related to afferent and centrally generated events.

This is an expensive book (\$170 US), but worth it for any physician wanting an up-to-date review of autonomic nervous system physiology that also includes the discoveries of many years ago. The emphasis on integrative action of physiological processes is an added bonus.



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Dear Colleague:

Diagnosing pain - especially chronic or recurrent pain - is a neglected art. However, if certain well-known neurophysiological principles are applied, diagnoses can be made in systematic and logical ways. An example of this can be found in thinking about "glove and stocking" pain.

Treating "glove and stocking" leg pain after failed back surgery
"Glove and stocking" pain is sometimes described as "non-anatomical", meaning that the pain cannot be explained by existing knowledge of anatomy. In fact, the patient may be suspected of having pain of psychogenic origin or even an agenda of secondary gain. The "psychogenic" part may not be far from the truth in certain cases, but the whole phenomenon is better explained by recognizing that "glove and stocking" pain is mediated primarily by the autonomic nervous system (ANS).

ANS-mediated pain has certain distinctive characteristics. It may have a burning, hot or tingling quality and may be hard for the patient to localize. Sufferers may complain of the pain in an obsessive way - hence accusations of "neurotic" pain. Often, little can be found on physical examination but skin temperature may be altered (either warmer or colder) and subtle changes in moisture and color may be detected. In its most extreme presentation, it is easily recognized as "sympathetic dystrophy".

Case in Point:

A 40-year-old woman underwent lumbar discectomy for left-leg sciatica. The surgery appeared to be successful with complete relief of leg pain, but after a few weeks another leg pain came on, more diffuse in distribution and different in quality. Physical examination indicated no nerve root signs and over 80 degrees of straight leg raising. MRI of the lumbar spine showed no sign of nerve root compression.

Autonomic response testing indicated an "interference field" (or focus of electrophysiological instability) in the surgical scar. The scar was infiltrated with a few cc's of procaine ½ % followed by an intravenous bolus of the same solution and the leg pain immediately disappeared. After about four days, the pain returned with a slightly greater intensity. Again an interference field was found in the scar and was treated as before. This time the pain relief lasted two weeks and the pain was less intense on relapse. A third treatment resulted in a permanent cure.

Treatment of failed-back-surgery syndrome is one of the most spectacular applications of neural therapy. An interference field in the surgical scar is the most likely cause, with an interference field in the ipsilateral third lumbar sympathetic ganglion the next most common.

Injection of the sympathetic ganglion is equally effective and although technically more difficult than scar injection, can be learned easily and performed in an office setting. (Injection of ganglia in neural therapy does not require the same accuracy as deep injections of anesthesia).



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Alternatively, injections can be avoided altogether by treatment with an electrophysical device. The TensCam, available from Charles Crosby, DO (407-823-9502), is recommended and seems to work as well as injections.



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Dear Colleague:

Mechanical mid-back pain can be a diagnostic challenge. Pain in this area (from, say T6 to L3) is less common and the mechanics of the area are less complex than in the low back. Yet the results of mid-back pain treatment by manipulation or other physical means can be disappointing, even in the hands of skilled therapists. When this happens- or preferably even before - consider the presence of abnormal reflex activity from visceral organs.

Consider the effects of viscerosomatic reflexes. The existence of reflex connections between soma and viscera is standard medical knowledge. Paralytic ileus is a well-known complication of L1 compression fracture and general surgical textbooks remind us that mid-back pain can be a sign of "silent" duodenal ulcer.

What is less apparent are the *frequency and extent* of these viscerosomatic and somato-visceral reflexes. If looked for carefully, they are surprisingly common and detecting them can be the key to successfully treating some of these "tough" cases. And neural therapy is an ideal method of treatment.

Case in Point

A 45-year-old self-employed painter presented with five years of bilateral mid-back pain initiated by a lifting-twisting strain. The pain was worse at night and during the day was exacerbated by certain movements, such as lifting or digging in his garden. Skilled chiropractic, osteopathic and physiotherapeutic treatment and massage had given no lasting relief.

His general health was good with the exception of quite severe heartburn for the previous 10 years and some fatigue. A measure of relief from the heartburn was obtained by taking Zantac and avoiding coffee, pop and greasy foods. He was under considerable stress from a failing marriage.

On examination of his musculoskeletal system, no abnormality (somatic dysfunction) could be found, apart from tension in the lumbar and thoracic para-spinal muscles. However autonomic response testing revealed an interference field at the gastro-esophageal junction.

Neural therapy using quaddles of dilute procaine into the overlying skin resulted in one day of complete relief of the back pain, but no change in the heartburn. Repeat neural therapy a few weeks later resulted again in only temporary relief of the back pain and no change in the heartburn.



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This response indicated that not just the interference field, but its underlying cause needed to be treated. Non-pharmaceutical treatment using nutritional supplements (beyond the scope of this article) resulted in the heartburn settling within two weeks, but the backache nevertheless persisted.

On the next visit, no interference field could be detected at the gastro-esophageal junction, but autonomic response testing indicated an interference field in the liver. This was not entirely a surprise, as the patient's occupation as a painter put him at risk for low-grade organic solvent poisoning, a common cause of liver stress.

This time, neural therapy of the liver produced what the patient described as an "awesome" response - heartburn gone, back pain reduced and improved energy and clarity of thought for a few days. He was put on an organic solvent detoxification program; liver interference fields were treated three more times; and nine months after his presentation, both the back pain and heartburn were gone and his energy and mental clarity were back to normal.

This case demonstrates that neural therapy sometimes has to be combined with other medical treatments to be lastingly effective. It also shows that neurological signals from more than one interference field often "summate" to produce a particular condition. Both the gastro-esophageal reflux and the liver interference fields were contributing to the mid-back pain. And both medical conditions had to be treated for the neural therapy to produce a lasting effect.

Prof. Alastair Ferguson is keynote speaker at Neural Therapy Retreat, Feb. 9-10, 2007, in Merrickville, Ontario, Canada.
The head of Queen's University Physiology Department, Professor Alastair Ferguson.



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Dear Colleague:

The acutely sprained ankle is not a difficult thing to treat. In most cases, elevation during the first day or two, taping and early mobilization does the trick. Within a few weeks, normal activity can usually be resumed.

Why is the sprained ankle not healing?

However from time to time, the natural course of events is delayed or even arrested.

After several weeks, considerable swelling is still present and the ankle is painful to use. When this occurs the question should be asked: what is impairing normal healing?

Osteopathic physicians usually recognize that untreated somatic dysfunction is present. In other words, there is a local mechanical dysfunction accompanied by a local autonomic nervous system reaction. The usual culprit is the distal fibula which is displaced slightly anteriorly, posteriorly or inferiorly, relative to the rest of the ankle bones. The displacement corresponds with a restriction of movement in the opposite direction, e.g. a posterior displacement of the distal fibula limits the ability of the fibula to move anteriorly, thus disturbing the mechanics of the whole ankle.

Displacement of the distal fibula cannot normally be detected by x-ray. The mobility and position of the fibula must be assessed by palpation, not an easy task for untrained hands. When somatic dysfunction is diagnosed, various manipulative techniques can be used to restore normal position and movement of the fibula. The response is almost immediate. Patients, often athletes or dancers, are immensely appreciative.

Neural therapy can fix it!

For those not trained in manual diagnosis or manipulation, neural therapy is an alternative method of treatment. It is very simple and is as effective as manipulation. But before describing its application, a few words about its rationale:

The displacement of a bone (or part of a bone) does not occur in a vacuum. The soft tissues connected to the bones determine where the bones sit and the tension in the tissues are regulated at least to a degree by the autonomic nervous system. As in the spinal column, neural therapy of the soft tissues surrounding the dysfunctional joint can correct the position and restricted movement of the joint. The technique, (described in my book) is the injection of "quaddles" or blebs of dilute procaine into the cutaneous or subcutaneous tissues overlying the area of concern, followed by a small bolus of procaine into a vein on the same side of the body as the joint being treated. In the case of the ankle, the quaddles are placed over the swollen



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area on the lateral aspect of the ankle.

The response is usually immediate: normal ankle movement is restored, pain is reduced and the swelling settles not long after. Usually only one treatment is required.

Neural therapy mid-winter retreat ♦ Sam Jakes Inn, Merrickville, Ontario - February 9th and 10th, 2007.

Plans are falling into place for this winter's mid-winter retreat. This will be an opportunity for those with some neural therapy training to refresh and develop neural therapy skills - in a relaxed and informal environment. The emphasis will be on diagnosis, trouble shooting and practical application of neural therapy. There will be lots of time for discussion and sharing of experiences in integrating neural therapy into medical practice.

Our keynote speaker is Professor Alasdair Ferguson, chairman of the Physiology Department at Queen's University in Kingston Ontario. An engaging speaker, he has a special interest in autonomic nervous system physiology and is currently conducting research into the circumventricular organs (CVO's). The ability of CVO neurons to respond to circulating factors which do not cross the blood-brain barrier provides the portal through which these substances exert feedback control on the brain.

We expect that Professor Ferguson will provide us with fresh insights into how the autonomic nervous system and biochemistry interact. Interference fields and their successful treatment often depend on biochemical status, so this is practical information, applied neurophysiology at its best.

Also on the program is Pierre Larose DDS who will speak on "Dentistry that every physician should know". Most physicians have only vague ideas about how dentists go about their business. Since neural therapy so often involves teeth, this is information that serious neural therapists need to know, if only to be able to communicate effectively with their dental colleagues.

Lynne August MD, creator of Health Equations - www.healthequations.com, will be speaking on nutrition, particularly as it pertains to cell membrane stability. Patients who are nutritionally deficient or neurotoxic respond poorly to neural therapy because their cell membranes are electrically unstable. This is a complex subject, but one in which Lynne has a great deal of practical experience.

I intend to do a review of basic neural therapy, discuss diagnosis and treatment of autonomic ganglia interference fields (including injection techniques), and provide practical approaches to diagnosing and treating neurotoxicities. Diagnosis and treatment strategies for chronic mercury toxicity will be discussed.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of Neural Therapy: Applied Neurophysiology and Other Topics

Dear Colleague:

This month I would like to discuss “conservative” treatment of lumbar spinal stenosis, a condition that we are seeing more of as the population ages. Incidence is difficult to evaluate but spine surgeons are now finding that spinal stenosis is the most frequent condition for which they operate.

How spinal stenosis presents:

Typically patients are elderly, although some may present in their 50's or 60's. Patients stand with lumbar spines and hips flexed and experience pain in the low back and/or leg(s) with lumbar extension. Walking more than a limited distance provokes pain. Sitting gives almost immediate relief.

The onset of the pain is usually gradual. Without treatment, the condition typically persists for many years. Because the mechanism of pain is encroachment on the cauda equina or a lumbar nerve root by narrowing of a canal, the definitive treatment has been considered (in some quarters) to be surgery.

For a more general discussion of spinal stenosis see: www.spinalstenosis.org.

What exactly is “conservative” treatment of spinal stenosis?

The list (by most medical authorities) is usually limited to anti-inflammatory medication, physiotherapy (whatever that means), corsets and caudal epidural steroids. In my experience, these are palliative treatments, although caudal epidurals (of procaine with or without steroids) may give months of relief in certain cases.

However things get interesting when we start looking at less conventional treatments. Among these I include manipulation, prolotherapy and neural therapy. None of these treatments directly address the narrowing of the canal. All target the conditions associated with the stenosis, e.g. poor mechanics, intervertebral instability, local inflammation and autonomic nervous system dysregulation.

Manipulation:

I had already begun writing this article when the current edition of the American Academy of Osteopathy Journal (December 2006) arrived with an article entitled “Non-operative management of spinal stenosis” by Phil Greenman. He reports on 15 patients with moderately severe symptoms who responded very well to a program of manipulation and intensive physiotherapy which included proprioceptive balance training, muscle stretching, muscle strengthening and aerobic conditioning. I personally have had some success treating spinal stenosis patients with manipulation and attention to muscle balance, but certainly not with results like this. Professor Greenman's report is a challenge to the fatalistic mind-set that so often surrounds conservative treatment of spinal stenosis.

Prolotherapy:

Prolotherapy (or ligament-tightening injections) has been used in treating spinal



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stenosis for many years and the internet abounds with claims of its efficacy. However no scholarly reports have been published to my knowledge. My own results of treating spinal stenosis with prolotherapy (over 28 years) is mixed, with perhaps less than half of patients responding. Whether this reflects my skill level or my patient population is hard to say, but prolotherapy certainly should in my opinion be considered for spinal stenosis. A relatively safe treatment that provides relief is always worth trying in any condition that does not improve spontaneously, even when the failure rate is high.

Neural therapy: There appears to be even less written about the use of neural therapy for spinal stenosis, at least in the English literature. Dosch's 1984 textbook does not mention it. However, if we consider manipulation to be a form of neural therapy in that it involves the autonomic nervous system, Greenman's report suggests that interference fields could indeed contribute to the spinal stenosis syndrome.

A recent case in my practice confirms this. A vigorous, otherwise healthy 65 year old man presented with four years of bilateral low back pain extending into his buttocks when standing for more than 20 minutes or walking for more than a few minutes. Sitting provided immediate relief. Sleep was disturbed by pain and narcotics were needed. A MRI demonstrated "significant central canal and foraminal stenosis". Previous osteopathic manipulation was ineffective, but an exercise program had helped. Apart from pain on lumbar extension and mild hamstring tightness, his musculoskeletal examination appeared non-contributory. Autonomic response testing indicated bilateral pre-vertebral sympathetic ganglion interference fields at the L3 level.

Both ganglia were treated for a little over a minute each using a Tenscam device. (For more information see tenscam.com). Immediate relief (less than 50% of the pre-existing pain) was obtained lasting about a week. At the next visit three weeks later, an interference field was detected on the left side only. Tenscam treatment resulted this time in more than two weeks relief, and a lower level of pain on relapse. Narcotic usage had declined significantly. On the third visit, an interference field was again found on the left side and was treated in the same way. On the fourth visit, this time after three weeks relief, an interference field was found in the right L3 sympathetic ganglion. It also was treated with the Tenscam.

A cure has not yet been obtained, although I am reasonably sure that it is on its way. However the point of this story is that the autonomic nervous system's involvement in spinal stenosis pain can be important. A variety of mechanisms could explain neural therapy's effect: e.g. alteration of local perfusion, improvement of intervertebral mechanics through optimization of muscle balance, regulation of local nociception, or perhaps some other mechanism.

All this is good news for patients with spinal stenosis. However it does require more effort and vigilance on the part of their physicians. Spinal stenosis is more treatable than we used to think.

Neural therapy mid-winter retreat - Sam Jakes Inn, Merrickville, Ontario - February 9th and 10th, 2007.

We are now only four weeks away from the neural therapy mid-winter retreat! Judging from the names of the people registered so far, this should be an interesting meeting. The best meetings seem to happen when imaginative people of diverse backgrounds come together - and that seems to be happening here!



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For those of you just joining in, the plan is like this: This will be an opportunity for those with some neural therapy training to refresh and develop neural therapy skills - in a relaxed and informal environment. The emphasis will be on diagnosis, trouble shooting and practical application of neural therapy. There will be lots of time for discussion and sharing of experiences in integrating neural therapy into medical practice. Our keynote speaker is Professor Alasdair Ferguson, chairman of the Physiology Department at Queen's University in Kingston Ontario. An engaging speaker, he has a special interest in autonomic nervous system physiology and is currently conducting research into the circumventricular organs (CVO's). The ability of CVO neurons to respond to circulating factors which do not cross the blood-brain barrier provides the portal through which these substances exert feedback control on the brain. We expect that Professor Ferguson will provide us with fresh insights into how the autonomic nervous system and biochemistry interact. Interference fields and their successful treatment often depend on biochemical status, so this is practical information, applied neurophysiology at its best.

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NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleague:

I was waiting to write this newsletter in the hope that our "Mid-winter Neural Therapy Retreat" would provide something interesting to relay to you, - and I was not disappointed. A number of "pearls" were presented by not only the invited speakers but also by the many talented and experienced physicians and dentists attending.

An old country inn in the Ottawa Valley was the venue, chosen because of its relaxed and comfortable environment. It was a great place to rest and relax, but participants instead chose to use every possible minute to learn, teach and exchange ideas. Far more information came forward than can be covered in this space, but for something a little different I chose the following, in the hope that you find it interesting:

Circumventricular organs:

Among the speakers was Professor Alastair Ferguson, a research neurophysiologist and chairman of the Physiology Department at Queen's University in Kingston, Ontario, Canada. He had been asked to provide us with a report of recent developments in autonomic nervous system research. This he did by presenting some of his own research on autonomic control neurons at the "blood brain interface", in the circumventricular organs. The function of these cells (that lie outside the blood brain barrier) is to sample the chemical properties of the blood and to send this information across the blood-brain barrier to the autonomic nervous system control centers.

TRP channels:

That these sensing cells even exist is interesting enough, but even more interesting is how they work. Embedded in the cell membranes are calcium channels, that when stimulated in a specific way allow inflow of calcium ions and a transient change in cell membrane potential. These channels are called TRP channels, TRP standing for *transient receptor potential*.

TRP channels respond to a variety of specific stimuli: some to changes in osmolarity, some to mechanical strain, others to temperature changes, to light, to various chemicals, to pheromones, cytokines, etc. They are found in all cells in all animals, from worms to mammals. Certain types of TRP channels are expressed more frequently in some cells and even in parts of some cells, hence Professor Ferguson's special interest in the physiology of the circumventricular organs.

TRP channels have been called "an ancient sensory apparatus for the cell". This is how primitive organisms lacking special senses sense their environments. But their presence in higher animals including man, shows that our ability to sense the environment, both interior and exterior, goes beyond our five special senses.



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Clinical applications:

These discoveries have a number of implications for physicians practicing neural therapy. Two stand out in my mind immediately:

1. The "internal milieu", or chemistry of the extracellular fluid affects autonomic nervous system function not just at the periphery, but also centrally through afferent signals to the autonomic control centers from the circumventricular organs. This supports the clinical observation that the success of neural therapy depends on a healthy internal environment. Attention to nutrition, allergy, toxicology and the patient's general medical condition goes hand in hand with effective neural therapy.
2. Autonomic response testing may be one step closer to possessing at least some scientific rationale. The autonomic response of the body to biologically active substances placed near it is hard to explain and perhaps research into TRP channel physiology will provide the answers!

Clinical observations often precede scientific explanations. TRP channel research is an area that neural therapists might want to follow in coming years.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

Fatigue is not a symptom that attracts much attention (from the medical community, that is). No specialty has taken "fatigue" under its wing and no anti-fatigue medication has yet appeared on the market. In fact, I suspect that most patients mentioning "fatigue" to their doctors encounter a certain (invisible) rolling of the eyes.

From the physician's point of view, our difficulty with fatigue is that we have received so little training in its diagnosis. It just does not rank in importance with pain, fever, cough, epileptic seizures and a host of other more pressing symptoms. Patients are aware of this and often do not even mention their fatigue, unless they are asked.

However, fatigue is important, not only in how it affects our patients' lives, but also as an indicator of their general health. It is not unusual for those in chronic pain to experience fatigue, but if fatigue preceded the onset of pain, the pain has a whole different meaning.

Asking patients when they last felt really energetic can be a key to understanding the pathophysiology of their pain.

The presence of fatigue is important in predicting the outcome of neural therapy.

Generally patients with fatigue do not respond as well to neural therapy as they should, presumably because of underlying malnutrition, toxic processes (including medication) psychological problems, etc. This whole subject is an important one, but too large to cover in this space.

However, occasionally one finds that an interference field is a cause of fatigue. A case is presented here:

A 58 year old electrician complained of fatigue of 7 years duration. His problems began in 1999 when he was injured at work, sustaining a complicated fracture of his right ankle and "torn ligaments" in his right shoulder. Multiple surgeries were required over several years for the ankle and shoulder, including plating of the ankle and a graft from his right "hip". During this period of surgery and rehabilitation he developed hypertension, diabetes, osteoporosis, a renal stone, cardiac palpitations and fatigue. Cushing Syndrome was diagnosed and a tumor was removed from his left adrenal gland in 2003. The hypertension and diabetes resolved but fatigue persisted.

An interference field was detected (using autonomic response testing) in one of the laparoscopic scars from the adrenal tumor surgery. Infiltration of the scar combined with an intravenous bolus of procaine ½ % resulted in immediate improvement in his energy level and relief from coincidental backache in the upper lumbar and lower thoracic regions. This improvement lasted for about a week. A repeat treatment in the same way a few weeks later resulted in a permanent resolution of both the fatigue and



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backache.

This case is another example of Dosch's injunction that:

"Any chronic illness can be due to an interference field!"

Dosch was able to state this on the basis of many years of clinical experience, but the theoretical explanation comes from Speransky* who showed experimentally that all illness, whether manifesting as pain, an inflammatory process, infectious disease, epilepsy, or whatever, is directed at least initially by the nervous system. The above example shows that fatigue, like any other disease process, can be neurogenic in origin as well.

So although fatigue is usually a confounding factor in neural therapy, the possibility should be entertained that fatigue is a result of an interference field and is therefore easily treatable.

* Speransky AD A basis for the theory of medicine. 2nd English ed. Dutt CP, translator. New York (NY): International Publishers; 1943.

A clinical tip from our dental colleagues at the recent Mid-winter Neural Therapy Retreat: When treating dental interference fields with procaine injections, avoid the gum margin. The gingival margin is exquisitely pain sensitive. It is not necessary to inject as far down as the dental root, (as shown in the Dosch atlas), but your patients will appreciate you avoiding this most sensitive area



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NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Volume 2, No. 4, April 2007

Dear Colleagues:

The concept of "tissue memory" is one of the more intriguing ideas encountered when learning neural therapy. That the body "remembers" the experience of pain is not hard to conceptualize, but remembering whole pathological processes with visible changes in the tissues is another matter.

The most dramatic example that I know of is Speransky's description of experiments in which infectious disease processes (such as tetanus or rabies) were triggered by irritating any part of the nervous system in animals that had recovered from an infectious disease many months before. This was in animals where no pathogen was any longer present! Another example is the Shwartzman-Sanarelli phenomenon (mentioned in the Dosch textbook on page 185) in which tissue memory of local skin allergy could be triggered by injecting the appropriate allergen into a remote vein, but could be blocked by infiltration of procaine into the sensitized tissue.

Tissue memories can be "recalled" by irritating the nervous system virtually anywhere, as Speransky and his co-workers showed. In these experiments, a nerve was cut or a tooth was broken, and an irritating substance such as croton oil was applied to the nerve tissue. Alternatively, a biochemically inert glass sphere was surgically implanted into the brain. The result in either case was that the subthreshold tissue memory came to the surface and an old pathological process "replayed".

Practitioners of neural therapy recognize that tissue memories are neurological "programs" or "behaviors" that can be triggered by activation of interference fields. Treating interference fields abolishes or at least reduces the activity of the tissue memories to a sub-threshold level. However they can recur under certain circumstances. Sometimes it is some sort of irritation in the vicinity of the old interference field, e.g. sciatica triggered by hemorrhoids, trigeminal neuralgia by maxillary sinusitis, or gastritis by a spinal somatic dysfunction.

At other times, latent interference fields can be activated by systemic factors. It is not unusual for old ailments or pains to recur when the patient is physically or emotionally stressed or is dealing with a systemic infection. Neurotoxins, in particular, can increase cell membrane excitability to the point that latent interference fields again become active. A case is presented to illustrate this point:

A healthy 61 year old man presented with vasculitis of his distal toes of both feet. This was a recurrence of an episode he had experienced five years before. (See plates 2 and 3 of the book "Neural Therapy: Applied Neurophysiology and other Topics"). On the previous occasion, the vasculitis had been triggered by an interference field resulting from an abrasion of his left second toe. Neural therapy of the abrasion using a Tenscam device resulted in a cure after four treatments.

On this more recent episode, there was no history of injury to the toes or anywhere else in the body. (The patient was remarkably healthy and in fact played hockey regularly). However in the two weeks preceding the onset of his vasculitis, he had a repair and cleaning of his heavily amalgam-restored teeth as part of a regular dental checkup. Autonomic response testing indicated that mercury released from the amalgam was the systemic factor that activated the "tissue memory" of the vasculitis.



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Mechanical disturbance of dental amalgam surfaces (as in chewing) has been demonstrated to release considerable mercury vapor. This can be clinically significant. It is not rare to see generalized arthralgia, pharyngitis, headaches and/or fatigue, often of many months duration, triggered by cleaning of dental amalgam. The patient is almost never aware of the relationship between the dental work and his or her symptoms.

This case was noteworthy because the physical findings were identical to those present when the vasculitis was triggered by an interference field from an abrasion. The lesson to be learned is that when a syndrome (or pain) recurs, the cause may be quite different from that which initiated the problem in the first place. And the cause may be systemic alteration in the patient's biochemistry.



Volume 2, No. 5, May 2007

NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

It is always interesting to see a new scientific explanation come forward to explain an old clinical observation. Although western medicine prides itself on its scientific underpinnings, it is not unusual for science to follow clinical practice rather than to lead it.

A case in point is neural therapy of **keloids**. The early neural therapists noticed that the scars they were injecting, (with the aim of treating interference fields), serendipitously softened and shrank the connective tissue. This observation led to injection of keloid scars for cosmetic reasons alone.

Dupuytren's contractures resemble keloids in that both exhibit excessive growth of connective tissue and both respond to injections of procaine. Dosch in his textbook "Manual of neural therapy", considered the abnormal connective tissue proliferation to be due to "chronic inflammation". Procaine has been known to possess anti-inflammatory properties since 1906, but the cellular pathophysiology underlying Dupuytren's and keloids has only been elucidated in recent decades.

The etiology of Dupuytren's disease is somewhat of a mystery. There is a strong hereditary component. Most victims are of Celtic or Scandinavian origin and the male to female ratio is 5:1. Occasionally Dupuytren's seems to be triggered by trauma, especially vibratory trauma, but most of the time onset is spontaneous. And although Dupuytren's shares with keloids the characteristic of excessive collagen deposition, it differs in that the connective tissue contracts. For a nice review of the clinical aspects and current surgical treatment of Dupuytren's check out: http://www.wsiat.on.ca/english/resources/medical/mlo/dupuytren_screen.htm

A key player in "fibrocontractive diseases" such as Dupuytren's and Peyronie's disease **is the myofibroblast**, a cell differentiated from fibroblasts by mechanical stress, the action of a cytokine, TGF- β , (which is also involved in triggering collagen formation) and by cellular fibronectin. The myofibroblast plays a physiological role in the remodeling of connective tissue; e.g. in granulation tissue it contracts, thereby shrinking the size of the wound as it heals. The molecule responsible for contraction is alpha smooth muscle actin, a form of actin normally found in smooth muscle.

Myofibroblasts are under sympathetic nervous system control and contract in the presence of adrenaline and angiotensin. When wound healing is complete, these cells normally disappear through apoptosis. It has been suggested that in fibrocontractive diseases, that this mechanism fails, leading to persisting



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myofibroblasts. Therefore just as beta blockers may impair wound healing, abnormal sympathetic signals may create an "excessive healing" response by promoting abnormal myofibroblastic activity.

Neural therapy has also been called "regulation therapy" and for good reason. Abnormal autonomic nervous system activity, (whether hyper- or hypo-) can be regulated by injecting procaine into the site of tissue disturbance. **In the case of Dupuytren's contracture, repeat injections directly into the nodule in the palmar fascia and at intervals along the course of the flexor tendons** will result in reduction in the contracture and softening of the tissues. It is not necessary to infiltrate all of the affected tissue. Dosch has suggested adding hyaluronidase to the procaine. Of course, the earlier the intervention in the progression of the illness, the better the response.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

Last month's newsletter on keloids and Dupuytren's contracture provoked an interesting question from Dr. Margaret Taylor <http://www.drmtaylor.com.au> of Fullarton, Australia. She raised the question as to **whether frozen shoulder could be related to keloids and Dupuytren's**. Orthopaedic surgeons describe inflammation and excess connective tissue in the shoulder capsule, so why not?

My first reaction to this question was to doubt a connection between these conditions because:

1. Frozen shoulder has a distinct neurological component, in at least some cases.
2. Frozen shoulder is usually self-limiting, resolving spontaneously after a year or two.

Perhaps the greatest story in the neural therapy narrative is Ferdinand Huneke's discovery of the interference field in 1940. A woman with intractable right shoulder "capsular arthritis", unresponsive to all treatments, is suddenly cured by injection of procaine into a scar in the left leg. This story, which is told in the Dosch textbook, does not give details of the shoulder condition. (In fact, "frozen shoulder" is an Anglo-American term and the German system of nomenclature of shoulder pathologies is different.) Nevertheless the picture is one of pain and severe restriction of shoulder movement followed by sudden resolution that can only be explained by a change mediated by the nervous system.

Dosch recommends segmental therapy into the skin, muscles and connective tissue of the shoulder region. Stellate ganglion blocks can be helpful. Dosch also advises searching for interference fields in the gall bladder and pancreas, and I have seen one frozen shoulder respond to treatment of a lung interference field. However these clinical observations do not directly answer Dr. Taylor's question: ***Are keloids, Dupuytren's contracture and frozen shoulder related?***

I initially suggested to Dr. Taylor that she ask her surgical colleagues to perform a biopsy of the shoulder capsule and look for myofibroblasts - key players in "fibrocontractive" diseases. A little later, when I had time for an internet search I found that this has already been done. In fact, **the histological similarity of Dupuytren's and the capsule of the frozen shoulder** was first reported in 1995 (Bunker). What is more, the same cytokine (TGF- β) that is involved in myofibroblast induction is active in both conditions.

A nice up-to-date overview of the clinical aspects of frozen shoulder can be found at <http://www.shoulderdoc.co.uk/education/article.asp?article=843>. And a fascinating report on the European Fascia Research Project on active contraction of fascia can be found



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at <http://www.fasciaresearch.de/ReportIASIyeaook06.htm>. I remember Professor Robert Ward, an expert in myofascial release technique, voicing his suspicion in the mid 1980's that **fascia was capable of active contraction**. This intuition has proved to be correct and shown to be directly affected by autonomic nervous system function.

What does this mean for neural therapy? I think this research continues to confirm Speransky's belief that all pathological processes are under nervous system control, even slowly developing conditions like Dupuytren's and frozen shoulder. It also confirms the clinical intuition and experience of the neural therapy pioneers such as the Huneke brothers and father and son Dosch.

For **detailed advice on treating frozen shoulder by neural therapy**, see the Manual of Neural Therapy According to Huneke (first English edition pp. 238 and 239). The recently released new translation (Second English edition) has enlarged this section and can be found on pages 191-193.

Which brings me to the latest news for all those interested in reading more about neural therapy: The long-awaited translation of the standard German textbook on neural therapy, **Neural Therapy According to Huneke** by Dosch has finally been released. Actually it has been available for a few months, but I did not become aware of it until a few weeks ago and I just received my copy from amazon.com.



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For neural therapy and advanced healing



Volume 2, No. 7, July 2007

NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleague:

This month I would like to review the newly translated 2nd English edition of Dosch's *Manual of Neural Therapy according to Huneke*. This is a long awaited book as the only previous neural therapy textbook available in English was the 1984 edition that has been out of print for many years. I am sure many other English speakers besides myself have been wondering what progress has been made since then - in Germany, the birthplace of neural therapy.

In particular I was wondering whether the North American contributions of Dietrich Klinghardt and Louisa Williams, i.e. their **invention of autonomic response testing** would be included in the "bible" of neural therapy. Sadly they are not, but an explanation is not hard to imagine when one considers how textbooks are made. Textbooks are enormously difficult and time-consuming to write, edit and publish. The information in most textbooks is usually five years out of date by the time the book reaches the reader. So this most recent (1995) edition really describes the state of neural therapy in Germany in about the year 1990, i.e. it is already close to 20 years old.

This disappointment aside, it is still an important book. The general outline and most of the writing of the previous edition has been left intact. This is as it should be, as the original translation was a magnificent book. The late Peter Dosch was not only a master clinician, but also a very fine writer. In addition, the English of translator Arthur Lindsay was (and is) a delight to read.

Most of the changes in the text have been **insertions of new scientific knowledge** and (in the techniques section), information on safety issues. For example the section on "Theories of Pain and the Effects of Anesthesia" has several new paragraphs on axoplasmic transport and the function of polypeptides such as substance P - old stuff in 2007, but nevertheless helpful for clinicians to understand the phenomena of neurogenic inflammation. Some of **Pischinger's** major contributions to the physiology of the extracellular space as it pertains to neural therapy are also included.

Some small subsections have been expanded and/or rewritten, e.g. injection techniques of some of the arteries, joints and nerves and the section on segmental therapy. There has also been some minor reorganization of material in certain places. For example the shoulder joint section of the "Encyclopedia" has been extensively rewritten.

A disappointment for me was the "**Failures of Neural Therapy**" section, which has been left unchanged. Although nutritional deficiency is briefly mentioned as a limiting factor of neural therapy's success, in my opinion, malnutrition and neurotoxicity is now epidemic in modern industrialized society and cannot be ignored by anyone practicing neural therapy. This is especially true in the practices of more progressive physicians who attract difficult cases,



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most of which are complicated by biochemical and/or immunological problems.

However the author does provide a couple of interesting little sections on **autohemotherapy** and **ozone-oxygen therapy**, to be used when neural therapy fails. More of this sort of thing would be a valuable addition to the book.

Thieme publishers have reduced the size of this edition from 500 to 400 pages by decreasing the size of the print and eliminating or shortening some non-text sections. The beautiful portraits of the Huneke brothers are gone - a sad mistake in my opinion. This is a personal book by someone who obviously admired and loved these courageous medical pioneers.

The extensive "Selected bibliography" and "Bibliography of Publications in English" has been replaced by a small section of "**Further Reading**". Interestingly, some of these recommended papers and books have been published in the last few years, i.e. are more recent than the text itself. Although this remedies the datedness of some of the material to a certain extent, it does not excuse the complete lack of footnotes, endnotes or bibliography.

New illustrations have been added and many of the dark old photographs have been replaced with photographs or diagrams from Matthias Dosch's *Atlas of Neural Therapy*. These photographs look more professionally produced, but I quarrel with the hand and syringe positions in some of the injection pictures.

This book is a must for any physician practicing neural therapy. However for those who already own a copy of the first edition, because the substantive changes are minor this second English edition might be considered an optional purchase.



Volume 2, No. 8, August 2007

NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleague:

Neural therapy is not usually thought of as a treatment for psychological problems. To be sure, relief of pain and other symptoms of illness can give a lift to the psyche, but neural therapy as a treatment for emotional distress? - This seems unlikely. However there is one relatively common circumstance where immediate and impressive relief of emotional pain can be obtained through neural therapy. That is in certain instances of acute depression.

The word "depression" is all too often used to signify a diagnosis, when its use should really be limited to description of a symptom or perhaps a constellation of symptoms (sadness, listlessness, fatigue, etc.) The impetus behind employing the term depression for a diagnosis seems to be that immediate treatment with antidepressant medication is then justified. Symptomatic relief may be obtained, but attention is diverted from making a true diagnosis and finding a more rational solution to the patient's distress.

The treatable causes of depression are too numerous to be discussed here, but commonly overlooked ones in my own practice are hepatotoxins such as mercury (from amalgam fillings) organic solvents and some medications, vitamin B12 deficiency, hypocholesterolemia, hypothyroidism, dietary protein deficiency (in vegetarians) or combinations of the above.

You will note that at the top of my list is hepatotoxins. In fact, with unexplained depression, the first place I look is at the liver. For those of you familiar with Chinese medicine, this should come as no surprise as the liver has been associated with anger and depression for millennia. In Western culture, an example of this association may be seen in alcoholism, where anger and depression are never far from the surface.

From a neurophysiological standpoint, the autonomic nervous system reacts when the liver is stressed by toxins or infection. The liver itself may then become an "interference field" and begin to function at a suboptimal level. With this often comes depression, fatigue, apathy and/or irritability.

If a liver interference field is suspected in a patient presenting with depression, the first step is (as always) to take a careful history, particularly asking about the few weeks or months preceding the onset of symptoms. Exposure to new toxins in the workplace, in the home, in personal care products (lotions, creams, etc.), medications, vaccinations, dental work, etc. may all be significant. Alternatively, chronic (compensated) exposure may suddenly become a problem (i.e. a decompensation occurs) if an additional stress is added to the patient's system, e.g. a viral infection, dental work, a change in diet, overwork, personal conflicts, etc.

Mild environmental toxic exposures do not usually cause problems in otherwise healthy people. However those who have experienced serious liver stresses in the past, e.g. hepatitis, infectious mononucleosis, or drug overdose (especially acetaminophen) are more vulnerable. Their livers carry the "memory" of the previous insult and the autonomic nervous system is then more likely to react in an exaggerated manner, such that an interference field is created.



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For neural therapy and advanced healing



A positive response with autonomic response testing confirms the diagnosis. (See Chapter 4 of my book available at <http://www.neuraltherapybook.com>. Treatment usually requires three steps:

1. Remove the toxin. e.g. If skin lotions containing organic solvents (such as Vaseline) are being applied to the body, this must stop.
2. Begin a detoxification program. The program should be tailored to the type of toxin involved and the patient's own specific detoxification weaknesses. (See Chapters 9 and 10 of the above book).
3. Treat the liver with segmental therapy. (See Chapter 5).

Neural therapy of the liver can in some cases give instant relief, i.e. an immediate improvement in mood and energy level. This happy result may occasionally be permanent, but more commonly repeat sessions of neural therapy in conjunction with the detoxification program are needed, i.e. the neural therapy gives a "boost" to the liver until the liver can function normally on its own.

There is probably no better example of the organ-emotion connection than that between the liver and depression. Judging from the sales of antidepressant medications in our society, depression is epidemic. Physicians should be on the lookout for these easily treatable causes and then use neural therapy to sometimes give spectacular relief.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

This month I would like to discuss a problem encountered sooner or later by physicians learning the art of detecting interference fields. The problem is this: A patient presents with a complaint that is found to be caused by an interference field. The interference field is treated with neural therapy; the symptom resolves; but the patient then returns with another complaint and another interference field.

One or two additional interference fields may simply be an example of the body "peeling the onion". i.e. allowing the less urgent problems to manifest after the more important ones resolve. However, if interference fields continue to appear, the physician is probably dealing with a situation of generalized cell membrane instability.

If the concept of "cell membrane instability" has a familiar ring to it, - yes, - an interference field itself is a product of cell membrane instability, but only in a specific location. Generalized cell membrane instability refers to tissues everywhere in the body, but most noticeably of nerve and muscle. A low resting membrane potential allows an influx of sodium ions, thereby lowering the membrane potential further and encouraging more sodium entry - a classical positive feedback loop. If enough sodium enters the cell, (unwanted) action potentials arise. Neural therapy prevents this by closing sodium channels, raising membrane resting potentials and stabilizing membrane electrical properties.

With generalized cell membrane instability, the threshold for action potentials in all cell membranes is lowered, although not to the degree present in a specific interference field. However, if latent interference fields are present, under these circumstances they are more likely to become active, - hence multiple interference fields simultaneously or sequentially. The sketch on the cover of my book is meant to illustrate this principle; the horizontal line (the threshold potential) goes up or down depending on the level of stability of cell membranes.

What then causes generalized cell membranes instability? The list of causes is long. It includes electrolyte imbalance of the extracellular and intracellular environments, nutritional deficiencies affecting the cell membrane, and toxins that poison the biochemical machinery of the cell membrane. These causes are covered in some detail in chapters 8, 9 and 10 of my book available at <http://www.neuraltherapybook.com>.

In this newsletter, I would like to talk about a newly discovered neurotoxin. It is not mentioned in my book and as far as I know has not yet been connected with less-than-successful neural therapy. For several decades this substance has been known to be toxic (to some people) in the gut and in the skin, but only recently has it been identified as a common cause of peripheral neuropathy and ataxia (with cerebellar degeneration), as well as autonomic nervous system dysfunction, myopathy, episodic headaches, and various psychiatric disturbances, especially depression.

This newly discovered neurotoxin (as you may have guessed) is gluten, the protein



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usually identified with celiac disease. For an excellent review of the gluten-neurological disease connection see: Hadjivassiliou et al, "Gluten sensitivity as a neurological illness" J. of Neurology, neurosurgery and psychiatry 2002; 72:560-563. (You will have to register, but it is worth it) at: [Neurotoxin Review](#).

What may come as a surprise to many is that 50% of these people with gluten induced neurological diseases have no gastro-intestinal symptoms or signs. Gluten sensitivity is therefore likely to be a missed diagnosis without a high degree of suspicion. Fortunately, certain "red flags" help to raise awareness. Because gluten sensitivity is an inherited condition, osteoporosis, difficult to treat iron-deficiency anemia, depression, cancer (especially lymphoma or cancers of the gut), various skin conditions, diabetes, multiple sclerosis and autoimmune diseases in the patient or family members are reasons to be suspicious.

Gluten sensitivity used to be a difficult diagnosis to make. In the 1960's small intestinal biopsy was the only definitive method. During the following decades serum anti-gliadin anti-endomysium and anti-tissue transglutaminase antibody tests were developed. These demonstrated that gluten sensitivity was much more widespread than previously thought, but it was only in the 1990's when fecal antibody tests were developed that the true extent of gluten sensitivity became apparent. Some confusion still exists in research as well as clinical circles about the nature of gluten sensitivity versus celiac disease, but the case for fecal testing is strong. See Fine's discussion of various methods of testing in <https://www.enterolab.com/StaticPages/EarlyDiagnosis.htm>.

Testing is now quite simple. I have my patients contact <http://www.enterolab.com>, have a collection kit mailed to them and have them return it with a fecal sample. A copy of the report is usually sent to my office, but otherwise everything is handled by the patient.

Multiple interference fields or poor response to neural therapy are not signs of neurological disease, but they may be looked upon as signs of cell membrane electrophysiological instability. Gluten sensitivity must now be added to the differential diagnosis of underlying causes. In my patient population I am finding gluten sensitivity far more common than I had ever realized. Identifying (and treating) gluten sensitivity can benefit a patient's health in many ways. It also makes neural therapy more effective and more rewarding.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

One reward of sending out these monthly newsletters has been the interesting feedback received from readers around the world. Comments and questions from many places have resulted in some stimulating discussions.

The last newsletter (on gluten as a neurotoxin) has generated **the biggest response of any newsletter by far**. It is clear that the significance of this discovery is appreciated by many, and by some long before I did. One correspondent wrote: "I am glad that I stopped eating wheat 25 years ago---I do miss bagels---but I know my brain works better on other fuels".

Dr Margaret Taylor, of Australia wrote: "In my workshops for doctors and podiatrists, I teach prolotherapy and neural therapy, and strongly urge them to look for undiagnosed coeliac disease and (milder) gluten intolerance. I have been doing so since I started teaching it in 1998 - probably since I am a coeliac myself I am more aware of it. **I agree it is a strong reason for non-response to prolotherapy and neural therapy**".

Dr Rainer Kumm, formerly of Germany and now introducing neural therapy to the UK, has on a number of occasions updated me on the status of neural therapy in Europe and South America. In the context of gluten sensitivity he comments: "Dr Barop who is I think the most important current text book author in Neural Therapy after Dosch constantly stresses the importance of the gut as Interference Zone in his seminars, such as last year in Baden Baden".

Then Dr Kumm teases us (at least those of us who do not understand these languages) with this statement: "As for Dr. Barop, his books are translated into Russian, I believe also Turkish and Italian but not English. From a didactic point of view Dosch is better, because of those numerous case histories, but Barop is more up to date with current research..."

It is striking how many correspondents have already identified gluten sensitivity in themselves or family members. My colleague, Dr Barb Powell of Ottawa, who has taught me most of what I know about this subject, learned about it the hard way - by she herself developing a host of serious complications, before her own diagnosis was finally made.

Again thank you for all the interesting letters. Keep them up and if anyone has a short case history or other pearl that they would like to share, I would be happy to include them in future newsletters.

One last thing: **a tip for prolotherapists** (I sense from the correspondence that there are quite a few out there). If the pain from the prolotherapy injections is inordinate or the pain worsens with treatment, an interference field may be present. A case in point:



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A 54 year old woman presented with two years of low back pain. All somatic dysfunction was treated with manipulation and a search for interference fields was made. None were found. The pain pattern was that of the "theatre-cocktail party syndrome" and the patient was in otherwise good health, so prolotherapy of the major low back ligaments was instituted using dextrose 12.5 % and procaine ½ %. After two sessions of prolotherapy two weeks apart, the low back pain was noticeably worse, an unusual development.

This prompted another search for interference fields. Using autonomic response testing, one was found at the coccyx. This was treated by neural therapy and the pain improved markedly immediately. In fact the response was so satisfactory that no further prolotherapy was necessary.

An increase in pain after neural therapy usually means that a more significant interference field has been missed, but is somewhere near by. The same phenomenon is true with regard to prolotherapy. It is always best to find and treat interference fields before instituting prolotherapy, but they are not always apparent right away. Sometimes they are "below the surface" and do not appear until the situation has changed. **If the prolotherapy injections are unexpectedly painful, or the pain increases after the injections, think about the possibility of a latent (or missed) interference field!**



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

This month I would like to discuss some more reasons why the liver is so important in neural therapy. I have in previous e-newsletters emphasized that the liver is the most common organ interference field and that it is often involved in depression. However liver interference fields can have other manifestations, some of them obvious and others relatively subtle.

First a little neuroanatomical review: The liver's pre-ganglionic sympathetic nerves derive from segments (approximately) T6 to T11, enter the abdominal cavity through the splanchnic nerves and synapse in the celiac plexus. Post-ganglionic fibers follow hepatic branches of the celiac trunk to the liver. Parasympathetic preganglionic fibers derive from the vagus nerve, pass through the celiac region and follow the blood supply to the liver.

A significant proportion of the nerve fibers in these nerves are actually afferent in nature - approximately 90% of the vagus and 50% of the splanchnic nerve fibers. Many of the vagus afferent fibers carry regulatory information such as plasma glucose concentration, osmotic pressure and temperature. The splanchnic nerves carry pain sensation from stretch receptors and bradykinin stimulation. Apparently the vagus nerve does not carry pain sensation.

Most authorities say simply that "little is known about autonomic nervous system effects on liver function" except that sympathetic activation increases the output of glucose. Some intriguing recent research at the University of Manitoba <http://umanitoba.ca/faculties/medicine/units/pharmacology/1833.htm> indicates that the autonomic nervous system's regulation of liver function is more complex than that. A new hormone, called "HISS" or "hepatic insulin sensitizing substance" has been found to be released by parasympathetic fibers in the liver in response to elevated insulin levels. HISS activates glucose uptake by skeletal muscle. Failure of this mechanism may explain the insulin resistance found in liver disease and obesity, and of course may also occur when the liver becomes an interference field (speculation on my part!).

Now let us get back to less speculative knowledge of the effects of a liver interference field: It has long been known that liver problems can refer pain to the right interscapular area and/or the right C4 dermatome (or upper shoulder area). Less well known is a somato-visceral reflex from the liver disturbing the mechanics of the lower thoracic spine. In osteopathic language, a liver interference field may cause "somatic dysfunction" in the lower thoracic spine. This may in turn cause low backache.

A simple screening test for lower thoracic spine somatic dysfunction is to assess the patient's ability to rotate the upper trunk to the right and to the left while in the sitting position. If limitation of range of motion is present in one direction but not the other, there is a good chance that a somatic dysfunction is present. But if the underlying cause is a liver interference field, manipulation of the spine will either not work, or will provide only temporary benefit.



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Look for the usual signs of low grade liver dysfunction: depression, fatigue, malaise, loss of appetite etc. and if an interference field is found, treat it with neural therapy. Of course, it goes without saying that any concurrent cause(s) of the liver interference field, such as organic solvent toxicity, hepatitis C, medication adverse effects, etc. should be treated as well.

The practical application of this lesson: In patients with low back pain, if spinal manipulation of the lower thoracic spine is not working, consider the liver as a possible interference field.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

This month I would like to discuss tinnitus, a symptom that affects about 10% of the adult population. Despite its prevalence, there are still some surprisingly large gaps in our knowledge about it. Most of the time a *cause or causes* can be found but understanding the *mechanism(s)* is another matter.

For example, one cause of tinnitus is head trauma. However, how and where trauma affects the auditory mechanism is in most cases a mystery. A great deal of speculation about damaged cilia, etc in the inner ear passes for fact when in reality the inner ear is a difficult organ to study directly and little is known about local pathophysiology

We know that not all tinnitus comes from the inner ear. Acoustic neuroma (8th nerve) is a possible cause. Surgical resection of the auditory nerve has shown that some tinnitus is central in origin and can be independent of the ear. Imaging studies indicate that tinnitus is linked to abnormal activity in the inferior colliculus, the auditory cortex and other related parts of the sound processing pathway termed "auditory association areas".

In recent years, the autonomic nervous system has been receiving increased attention. Sympathetic fibers from the carotid plexus are known to penetrate the ear through the tympanic cavity. These are presumably vasomotor in nature and most often act as vasoconstrictors. One interesting study has shown a correlation between "vibration-induced white finger" and tinnitus - presumably both conditions caused by prolonged vasoconstriction. Other studies have shown correlations between tinnitus and systemic manifestations of autonomic nervous system imbalance, such as suppression of heart rate variability and serum serotonin levels. The correlation was strongest in those patients who were experiencing the highest levels of distress from their tinnitus.

This last observation leads to another subject, namely the difference between the intensity of the tinnitus and the level of distress that is experienced. The vast majority of those experiencing tinnitus tolerate it well and feel only mild discomfort. Some however become upset and 1% experience it to the extent that it interferes with daily life. It is this smaller group that appears to have the strongest autonomic nervous system involvement.

Of course any pathophysiological process involving the autonomic nervous system is a candidate for treatment by neural therapy. The trick then is to find the interference field that may be triggering the abnormal response.

History can occasionally be helpful. Exposure to noise or ototoxic medication usually indicates irreversible structural damage, unlikely to be helped by neural therapy. (I have seen one case of tinnitus that began shortly after a vaccination). If head or neck trauma preceded the onset of symptoms, the mechanics of the head and neck should be examined carefully, ideally by someone competent in cranial osteopathy. The same applies if the intensity of the tinnitus is affected by posture, or by neck or jaw



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movement.

If the tinnitus is accompanied by nausea and vertigo, Meniere's Syndrome is likely. A pulsatile tinnitus may indicate a vascular malformation.

However much of the time the history provides no clues. And the standard physical examination is of little help. One exception is the discovery of impacted earwax, the removal of which may provide a cure! For those skilled in myofascial examination, Travel and Simons' textbook describes trigger points in the masseter muscles, the sternocleidomastoids and the temporomandibular joints. In my experience these trigger points are usually secondary to mechanical imbalances, dental problems or other interference fields.

The Dosch textbook suggests a series of test injections, starting with an intravenous bolus of procaine, followed by injections into various acupuncture points around the ear and the stellate and otic ganglia. Surprisingly, no mention is made of wisdom teeth as triggers of tinnitus, (except in a general discussion of dental interference fields). In my experience, upper wisdom teeth or the scars that remain after their extraction are not rare causes of tinnitus. At times, procaine injections alone will provide cures. At other times isopathics must be added to the procaine. More commonly extraction or surgical debridement of cavitations (or NICO lesions) is necessary.

For those reluctant to subject their patients to a series of often fruitless injections, autonomic response testing is a simple answer. It seems to shine especially in the mouth, where interference fields can be detected with great precision - discriminating between the buccal and lingual aspects of a tooth for example.

Tinnitus is common and most of the time untreatable. However, as in so many medical conditions, the possibility of an easily treatable interference field should always be considered. You owe it to your patient and to your self to look for them.



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NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

Some unfinished business with regard to last month's newsletter on tinnitus: First let me thank you for the feedback on newsletter length and for the constructive criticism, suggestions and encouragement. The consensus seems to be that a page and a half is about the right length, so I will continue to aim for that.

Secondly, Dr. Margaret Taylor of Fullarton, Australia draws our attention to the importance of zinc in the treatment of tinnitus. She has sent a list of abstracts and titles of research papers on this subject that I would be happy to forward to anyone interested. As Dr. Taylor reminds us, the sensory tissues of the inner ear have the highest concentrations of zinc of any tissues in the body.

I have tried in these newsletters to keep "on topic", i.e. discuss subjects as closely related to neural therapy as possible. However as readers of my book at neuraltherapybook.com know (chapter 8), I feel that the development of interference fields and nutritional deficiency is often connected. This relationship is ignored in the Dosch textbook, but explored by Pischinger in his monograph, "Matrix and Matrix Regulation", where nutritional deficiency, especially of minerals is considered to be an "irritation of the ground system", (or of "the matrix", or of the fascia, or of the extra cellular system - take our pick!). Irritation of the ground system is the same thing as an interference field, in this way of looking at things.

While generalized neurotoxicity or nutritional deficiency may result in interference fields in many areas, some tissues are more vulnerable to these stresses than others. For example, it has been known since the 1920's that the adrenal glands are the first organs in the body to decompensate under conditions of starvation. Adrenal fatigue (or fatigue that is worsened by physical activity) is therefore almost always a sign of at least some nutritional deficiency.

Other tissues with specific nutritional vulnerabilities include the thyroid and breasts (iodine), the prostate (zinc), red blood cells (iron), pancreas (chromium), muscles - (magnesium and calcium) etc. And it stands to reason that a tissue under nutritional stress will be more vulnerable when stressed in an additional way, e.g. by a related interference field.

Interference fields may result in no symptoms and they may produce symptoms in remote regions of the body. I find it useful to think about why an interference field might manifest in a particular place. Why does a wisdom tooth interference field cause tinnitus in one patient and sacroiliac joint instability in another? I believe the answer is that (at least in some cases), the place that becomes symptomatic may be borderline nutritionally deficient. In these situations, it would seem reasonable to use both neural therapy and nutritional supplementation to achieve a lasting good result. In the case of tinnitus, neural therapy would relieve the vasoconstrictive component and zinc would optimize the metabolism of the inner ear.

One more thing about wisdom teeth: Almost 50% of dental interference fields are



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found in wisdom teeth or wisdom teeth scars, and dental interference fields are common. So the energetic connections of this tooth are worth memorizing. These can be found in the Voll dental acupuncture chart found on pages 166 and 167 of my book, (copied with permission from the Dosch Manual).

From this chart, a connection between wisdom teeth and the C7 vertebra can be found. On reviewing this, I was puzzled as in my own experience I have often found somatic dysfunction at the C1-C2 (atlanto-axial) level* associated with wisdom teeth interference fields. This chart shows no dental connections with any of the upper cervical vertebrae. Of course it is possible to speculate that the atlanto-occipital joint is secondarily affected by dysfunction at the sacroiliac joint with its energetic connections to the wisdom tooth. Experienced manual therapists are aware of the upper cervical-pelvic ring association and the Dvorak brothers describe this relationship that they call "spondylogenic reflex syndromes" in their monograph "Manual Medicine".

While pondering this question I came across another Voll dental-acupuncture chart hanging on the wall of my examining room (I think I may have obtained it from Dr. Klinghardt years ago). On this chart, all the teeth connect energetically with the C1 and C2 vertebrae!

One of the practical applications of this knowledge is that in patients who have a poor response to manipulation of the C1-C2 vertebrae (or any other cervical vertebrae), a wisdom tooth interference field is a possible cause. Since atlanto-axial somatic dysfunction often goes with headache, particularly the type that refers to the forehead and/or eyes, this may be the pathway that explains how a bad wisdom tooth or wisdom tooth scar can cause chronic migraine headaches.

*Somatic dysfunction at the atlanto-occipital level can be detected as follows: With the patient lying supine on an examining table, the physician stands at the head of the table facing the patient. The upper cervical spine is passively flexed and the head rotated alternately to the right and to the left. If the range of motion is less in one direction than the other, somatic dysfunction is present.



Volume 3, No. 2, Feb 2008

NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

Students of neural therapy learn quickly that psychosomatics are important. And also that the mind can affect the body in a multitude of ways!

Most mind-body phenomena are physiological and serve some utilitarian purpose, e.g. a blush signaling embarrassment or secretion of saliva assisting digestion while enjoying an unhurried meal. (Of course when speaking of "mind" in this context, we mean the emotional part of the mind).

Hormones such as adrenaline and cortisol mediate mind-body phenomena, by provoking a generalized arousal of the whole organism. The autonomic nervous system acts in a more precise way, directing the nervous system's attention to specific areas of the body.

Problems usually arise when a psychosomatic reflex persists longer than the target organ or tissue is capable of responding. The organ (or tissue) then produces a symptom indicating distress. Often the psychosomatic nature of the symptom is not identified and much useless medical and/or other treatment is delivered.

Some of the neurological pathways between the emotional parts of the brain and the body are straightforward, e.g. The unresolved emotion-organ connections described in Chinese medicine and also in Chapter 11 of my book on neural therapy. Others are more indirect and affect the body in roundabout ways. Here is an example of a case I recently saw in my office:

A healthy, physically active, 40 year old woman presented with several months of intermittent numbness of her right hand and forearm. No history of preceding trauma or strain was elicited. The pattern of symptoms and exacerbating activities suggested a diagnosis of carpal tunnel syndrome.

An osteopathic-type examination of the whole musculoskeletal system was unremarkable except for somatic dysfunction of the upper thoracic spine and tension of the suboccipital muscles. "Arcing" or a sensation of "energy block" was felt in the thoracic diaphragm. (For those unfamiliar with osteopathic terminology, these findings indicated tension in the upper back, disturbed mechanics in the upper thoracic vertebrae, and tension in the suboccipital muscles - incidentally sometimes referred to in Chinese medicine as "worry muscles").

Treatment consisted of osteopathic "unwinding" of the thoracic diaphragm. (An equally effective treatment might have been segmental therapy over the upper thoracic vertebrae). At a follow-up visit a few weeks later, the hand and forearm symptoms had improved by 70%, but similar symptoms had begun to appear on the opposite side. Again somatic dysfunction was detected in the upper thoracic spine and the patient was treated manually as on the first visit. The response to treatment this time was even less - clearly time to look elsewhere!

With recurring somatic dysfunction in the upper thoracic spine and no history of trauma,



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I usually think of lower chest medical problems, e.g. GE reflux, cardiac or lung disease. Nothing helpful was available from her history, so I began touching the lower anterior chest using autonomic response testing. (For an explanation of this test see Chapter 4 of my Neural Therapy book). A weakening of an indicator muscle appeared when touching the low mid-precordium; a reversal of this weakening occurred when the patient touched her own forehead. This combination of findings indicated a psychosomatic stress on the patient's upper thoracic spine, probably from an unresolved "heartache". (See also Chapter 11).

The patient was gently questioned about heartache in her life. She broke into tears while revealing that her elderly aunt to whom she was very close was slowly dying of a lung disease.

The case is interesting because it demonstrates how complex the expression of a psychomatic stress can be. The mid-brain signaled love-sorrow to the "emotional heart" in the precordium. Through viscerosomatic reflexes, the upper thoracic spine developed chronic excess sympathetic tone. This spread into the arms provoking the patient's symptoms.

Recurring somatic dysfunction in any part of the spine may be due to a viscerosomatic reflex. And viscerosomatic reflexes may be expressions of unresolved emotional conflicts affecting the organ that corresponds to the specific emotion.

As promised in the last newsletter, I will continue to limit its length to about 1 1/2 pages. However this month I am adding some excerpts from letters - see below. Readers are invited to question, comment or otherwise contribute to the sum of our knowledge on neural therapy (and related subjects.)

Letters and comments:

From George Stylian DO. (gstylian01@optusnet.com.au)

Thank you again for another informative newsletter. Concerning somatic dysfunction of C1-2 and its relationship to tinnitus, I have found many of these strains related to somatic dysfunction of the occiput. For example, in a right torsion strain of the cranial base, the occiput dips down on the right and very often I find C2 strained in a lateral direction to the right. Feels like a translatory motion of C2. I have often wondered if this is a remnant of a right condylar parts compression during OccAnt presentation at birth?

Zn seems to be involved in just about every enzymatic action; so no wonder it is so important in tinnitus.



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From Rainer Kumm (r.kumm@doctors.org.uk)

(regarding tinnitus and zinc)

Yes, nutrition is relevant and commonly ignored, even simple things like almost ubiquitous D3 deficiency.

I find this book quite useful: Drug-Induced Nutrient Depletion Handbook (Paperback) by Ross Pelton (Author), James B. LaValle (Author), Ernest B. Hawkins (Author)

I learned for example that statins interfere with the CoEnzyme Q10 system, not really new but I didn't know that. That easily explains the fatigue often encountered as a side effect. I had this as a recommendation from a German "naturopathic" GP who says it is always on his desk.

From Robert Banner, Department of Anesthesia and Perioperative Medicine, University of Western Ontario -

When reading "Manual of Neural Therapy According to Huneke" I came across the concept of nasal conchae interference fields (Fliess/Leprince) pages 313-314.

I have used ART to locate and when appropriate 2 - point these fields. I have had excellent success with the pulmonary zone and urogenital zone ie. asthma and dysmenorrhea.

Comment is made but no explanation given that procaine cannot be used. They recommend 3 - 6% lidocaine. I have used Lidodan spray at 12% per spray, two sprays each nostril.

I think this is just amazing. Comments? Personal experience?

I am aware of the mapping of body zones in the nasal and oral mucosa as well as other places - ear, periumbilicus, feet, etc. I remember a presentation at an AAOM meeting a number of years ago by a German presenter who had discovered similar points in the anterior thighs! However I have not personally used any of them therapeutically.

I guess the question for me is: Is one portal to the nervous system better than another?

I suspect that the nasal one may be a particularly powerful entry zone. Perhaps you are aware of the experimental and therapeutic work done in the early 1900's and later using pledgets of cocaine inserted in the posterior nasal cavity. The target was the sphenopalatine ganglion and the technique was used for treating many things including chronic backache. If I remember correctly, Toronto was a center for this sort of research and activity. I know it carried on well into the second half of the last century. I used it for a short while in the 1980's. Ed Sheffman, a now retired anesthetist from Toronto was quite experienced in this.

Why the thumbs down on procaine? I have no idea. Perhaps it does not penetrate mucosa as well. There must be a reason why our ENT colleagues have held onto cocaine for so long. Enlightenment from the readership would be appreciated.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

A reader has asked about vaccinations and their relationship to interference fields. Vaccination is a controversial and polarizing subject, and one on which I comment with some trepidation. At one extreme the medical establishment seems to say "The more vaccinations the better!" On the other hand, homeopaths warn that a heavy price is paid for every vaccination in subtle ways. And in between, is the dilemma of parents having to decide whether, when and how much their young children should be vaccinated.

To make any headway on this subject in a short newsletter, separating out the contentious issues seems to be a good start. As I see it, vaccinations present four possible reasons for caution:

1. Overstimulation of the immune system. This is the observation of homeopaths who feel that although some specific immunity may be provided by vaccination, the immune system as a whole is weakened making it more vulnerable to other more serious diseases. "Have we traded mumps and measles for cancer and leukemia?" - R. Mendelsohn
2. Vaccines contaminated by viruses during the production process. This occurred on a massive scale with the early Salk and Sabin polio vaccines.
3. Toxic exposure from adjuvants: heavy metals, organic solvents and foreign proteins. Most adjuvants are preservatives which by definition are toxic. Supposedly Public Health risk:benefit calculations justify their use, but this is small comfort for the individual with a genetic susceptibility who has been injured by one or more of these toxins.
4. The "puncture phenomenon". This constellation of physiological reactions occurring after any needle puncture was discovered by a group of Austrian researchers under the leadership of Pischinger. Although it occurs with any needle puncture, and not just with vaccination injections, it pertains directly to interference fields, regulation and neural therapy. This subject will be discussed in more detail next month.

The first two risk factors are important, but lie outside my area of expertise and will not be discussed here. However the last two deserve careful attention as they are commonly encountered by physicians searching for interference fields and practicing neural therapy.

The vaccine adjuvant receiving the most attention in recent years is Thimerosal, a preservative containing (among other things) organic mercury. Because of an extraordinary increase in prevalence of autism and autism spectrum disorder in recent decades, a link to Thimerosal in vaccines has been proposed. Although a great deal of circumstantial evidence supports the connection, the regulatory authorities still insist that the case is not proven. However any physician who has had the sickening experience of being told by parents that emotional contact with their child was lost a week after their "two-year vaccinations" hardly needs that proof.

Pressure from autism activists (many of them physician-parents of autistic children) has



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forced the regulatory authorities in both Canada and the US to eliminate Thimerosal from some children's vaccines, but not all. A list of vaccines still containing Thimerosal can be obtained at <http://www.thimerosal-news.com/html/info.html>.

Of course autism is the tip of the iceberg. Many other problems can arise in vulnerable individuals, although the connection with vaccination may not be made. I have seen cases of chronic fatigue syndrome and severe (suicidal) depression triggered by vaccinations containing Thimerosal. That mercury was a causative factor was supported by a positive response to mercury detoxification. More commonly patients develop less severe symptoms such as arthralgia or flu-like symptoms for a week or two following their "flu shot". I wonder how many of these reactions are to the preservative and not to the vaccine itself.

Another practical application of this knowledge comes in autonomic response testing. Among the reasons for blocked regulation is toxicity of one sort or another. Faced with unexplained blocked regulation, the patient should always be questioned about recent vaccinations. Although vaccination by itself can block regulation for a time, for patients who are already borderline mercury toxic or who have mercury sensitivity (not the same thing), Thimerosal in the vaccine may be the cause of blocked regulation.

If the patient is already suffering from fatigue, depression or some other manifestation of low grade mercury toxicity, an exacerbation from a Thimerosal containing vaccination may confirm the diagnosis and make easier the decision to remove dental amalgam and undergo a detoxification program. However if the patient has been in otherwise good health, and simply displays blocked regulation after a vaccination, watchful waiting may be the wiser strategy.

In summary, adjuvants in vaccines act like all other neurotoxins. They block regulation, making detection of interference fields more difficult. And they affect cell membrane stability making treatment of interference fields less effective.

Next month I will discuss the "puncture phenomenon" and its relationship to vaccinations and to neural therapy.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

Last month I began a discussion of the **relationships between vaccinations and neural therapy**. I raised the concern that vaccinations may weaken the immune system as a whole even as it provides specific immunity to certain diseases. I also mentioned that vaccinations carry the risks of cross contamination with other biologically active substances and injury from adjuvants (preservatives), many of which are known neurotoxins. Vaccination can disturb autonomic nervous system function in various ways, making interference fields more difficult to find and sometimes more difficult to treat.

Vaccinations can also create interference fields. These interference fields can be complex (See Dosch's case history on p. 237 of his recent *Manual of Neural Therapy* or p.293 of the old edition) and can disturb physiology and even biochemistry in unusual ways. This complexity is probably due to a combination of physical, chemical and immunological factors challenging the body all at the same time.

Even needle puncture of the skin produces a systemic response. The "**puncture phenomenon**" was discovered in the 1970s by a team of Austrian researchers (Pischinger et al) studying the physiology of the extracellular space. They discovered that needle puncture (not necessarily in an acupuncture point) **altered the biochemistry and physiology of the whole organism**. In addition, the disturbance was **asymmetric and more pronounced on the side of the body with the puncture**. Oxygen saturation, electrolytes, granulocytes, immune globulins, cholesterol, and other venous blood parameters as well as skin temperature and electrophysical properties were all altered for at least five days.

Further research led to the discovery that **interference fields produced the same ipsilateral changes in venous blood chemistry**. In other words, body chemistry and physiology is different on the side of the body with an interference field.

The sometimes bizarre syndromes produced by vaccination is illustrated in this case:

A 38 year old woman presented with a band of paresthesia extending from her left lateral upper arm to her left cheek, in association with anxiety and a feeling of tightness around her throat. 6 weeks before, a tetanus vaccination into her upper arm had provoked the above-described paresthesia - lasting about two days. Another (flu) vaccination a month later into the same spot triggered an even stronger response, this time associated with pharyngospasm. Several emergency room visits involving treatment with adrenaline and antihistamines resulted in only temporary relief.

*Autonomic response testing revealed an **interference field in the vaccination site**. The response could be reversed with the presence of a homeopathic of "silberamalgam", a remedy often associated with hypersensitivity to mercury. **Both vaccinations included***



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Thimerosal, a mercury-containing adjuvant. Interestingly the patient's only previous health problem had been hypertension that had developed in her twenties during a period in which dental amalgam had been placed.

Neural therapy of the vaccination site using dilute procaine provided relief of her symptoms, but eventually all the dental amalgam had to be replaced in conjunction with a mercury detoxification program using DMPS. The parasthesia and throat symptoms gradually settled but recurred in a milder way over the years when the patient was tired or under stress.

This case demonstrates **the complexity of interference fields created by vaccinations**. Presumably this patient had developed a hypersensitivity to mercury from exposure to dental amalgam. The first (mercury-containing) vaccination then provoked a local response, but also altered the physiology of the left side of the body. These left sided changes created conditions for another local (left side only) reaction to the mercury in the amalgam-filled teeth.

Fortunately neural therapy (combined with detoxification of mercury) allowed for a restoration of more normal physiology in the affected areas and a cure for this patient.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of Neural Therapy: Applied Neurophysiology and Other Topics

Dear Colleagues:

This month I would like to highlight an always-interesting diagnostic challenge: namely, chronic pain in the upper shoulder. (By upper shoulder I mean that area between the glenohumeral joint and the neck).

What I find interesting about pain in this particular part of the anatomy is the wide variety of possible causes. Even when the pain seems to be "musculoskeletal" in origin, many other parts of the anatomy may be causing or at least contributing to it. These multifactorial situations are the most difficult to sort out. In fact, I am embarrassed to admit that a recent case that I saw in my office led me astray for awhile. The diagnosis was eventually made, but it was delayed and so was the treatment for longer than it should have. Here is the story:

A 58 year old man presented with slowly worsening left upper shoulder pain of 4 years duration. No preceding history of trauma or strain could be elicited. The pain could be exacerbated by elevating the arm and by carrying objects in front of the body.

His health was generally good and the only medication he used was a nasal spray to relieve congestion at night. Certain foods provoked heartburn especially if consumed late in the evening. Past trauma included a broken nose in his teens, and past surgery a left carpal tunnel release three years before.

Physical exam showed significant body asymmetry with the left shoulder lower than the right. Active and passive elevation of the arm allowed only 90's of movement. Flexion of the arm across the chest exacerbated the pain and the acromio-clavicular joint was tender. Right side-bending of the neck was restricted; the atlanto-axial joint was in left rotation and craniosacral movement of the vault, ethmoid and temporal bones was severely restricted. Unwinding of the nasal bones and the occiput resulted in a profound release.

However 3 weeks later he reported no relief. Over the subsequent months, increments of relief were obtained by treating the restricted side bending of the neck with manipulation, by treating an interference field in the left stellate ganglion with neural therapy and by administering prolotherapy to the acromioclavicular joint (9 session!). But after 8 months, the pain level was still 50% of that before beginning treatment.

Clearly, something was still missing! Oddly, even after all this treatment, the stellate ganglion was continuing to signal (autonomic response testing) as an interference field. The area that the stellate ganglion serves was reexamined and the carpal tunnel scar was noted. (This had not been considered significant previously, as the surgery had been performed after the onset of the shoulder pain). Nevertheless, infiltration of the scar (followed by an intravenous bolus of procaine) resulted this time in complete relief from the upper shoulder pain.

Upper shoulder pain has numerous potential causes. A good first place to look is somatic dysfunction of the neck, but somatic dysfunction almost anywhere in the body is also possible, especially shears of the sacroiliac joints and cranial lesions.



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Acromio-clavicular joint arthritis (or strains) refer pain proximally to the C4 dermatome (mostly upper shoulder). Interference fields from scars (almost anywhere) can be causative and teeth, especially upper eye teeth, are possible culprits. Pain can also be referred from the diaphragm and abdominal viscera - liver and gall bladder to the right and stomach and pancreas to the left. Large and small intestines can refer pain to either side.

As so often happens in chronic pain, more than one "pain generator" may be present. In this case, the carpal tunnel scar was almost missed because the surgery was performed after the onset of the pain. However it turned out that it was an important player and treatment was necessary to give the patient complete relief from his pain. In the upper shoulder especially, attention to many possibilities is sometimes required to solve these diagnostic puzzles.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

This month I would like to discuss the vagus nerves and their importance in neural therapy.

The vagus nerves are currently not attracting the attention that they once did. A few decades ago every medical student was taught the indications for vagotomy (usually in combination with partial gastrectomy) in cases of peptic ulcers. The idea was that severing the vagus nerves would decrease acid production and alter peristalsis in the stomach, thereby facilitating healing. This was before the invention of acid suppressing medication and the discovery of antibiotic-sensitive *h. pylori* in ulcers. These new treatments have made vagotomy (almost) "history".

See: http://www.ncbi.nlm.nih.gov/pubmed/15906900?ordinalpos=3&itool=EntrezSystem2.PEntrez.Pubmed.Pubmed_ResultsPanel.Pubmed_RVDocSum.

Other attempts to treat visceral illness by vagotomy were made in the first half of the twentieth century. In experimental work vagotomy was demonstrated to reduce inflammation in the lungs, stomach and peritoneum (in rabbits). However the price was weight loss, disordered gastrointestinal function and increased morbidity. The procedure therefore did not become established in clinical medicine except in cases of peptic ulcer disease.

The vagus nerve is a major conduit of information between the regulatory centers in the brain stem and the thoracic and abdominal viscera. Its interface with the abdominal viscera is not direct, but rather through the enteric nervous system. Most clinicians know that the vagus nerves carry parasympathetic nerve fibers, but many do not know that 80% of vagus nerve fibers are afferent, i.e carry information to the brain.

The vagus nerves also supply the thoracic viscera and small branches innervate the meninges, part of the external ear and ear canal, the pharynx and the larynx. Its role in a case of recurrent inflammation of the external ear can be seen in plate 1 in my book <http://www.neuraltherapybook.com>.

In my experience, interference fields in the vagus nerves most commonly occur in association with:

1. entrapment by the suboccipital musculature at the exits from the skull.
2. irritation of the small intestine, usually from food sensitivity.

Paediatric cranial osteopaths are very familiar with the first category. Infant colic is commonly associated with cranial somatic dysfunction, probably a result of birth trauma. One cranial manipulation is usually all that is required to give the baby (and its parents) complete relief. Presumably normalizing the tissue tension at the cranial base removes the irritation of one or both vagus nerves.

This phenomenon (vagus nerve entrapment) can also occur in adults. A case I saw recently in my office went like this:



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A 65 year old woman had been in excellent health until sustaining an injury at work 3 years ago. While pulling a heavy box off a shelf, the box slipped and she was struck on the right parietal region. The blow stunned her but no other sign of cerebral concussion ensued. From the time of the accident she developed difficulty with balance, vomiting 2 or 3 times a week and right occipital headaches 3 or 4 times a week. She had indigestion, could not eat full meals, but obtained some relief from vomiting. A slight woman, she lost 15 pounds and became underweight. Numerous investigations resulted in a diagnosis of "depression" and she was prescribed antidepressants, with no relief.

On the first visit the only positive physical findings were stiffness in the upper neck, greatly restricted cranio-sacral motion in the cranium and compression of the cranial base. No interference fields could be found in the head, neck or abdominal viscera. Treatment on the first two visits was osteopathic manipulation, resulting in reduced headaches, but little change in the gastrointestinal symptoms.

On the third visit an interference field was detected (by autonomic response testing) in the left vagus nerve. This was treated with the Tenscam device (an electrophysical modality producing an effect similar to that from procaine injections). The response was almost immediate - complete relief of all gastrointestinal symptoms. One further neural therapy treatment was needed a few weeks later. The patient now (three months later) appears to be cured.

Vagus nerve entrapment can occur with head or neck trauma and is not always relieved by manipulation. Neural therapy of the vagus nerve can give lasting relief.

The injection technique is described on page 418 of the old edition of the Dosch textbook and page 318 of the new one. My method is to insert a 1.5 in. 27 gauge needle medially through a point just posterior to the ascending ramus of the mandible and anterior to the mastoid. Draw back the plunger to make sure the needle is not in a blood vessel and then slowly inject 5 ml of procaine ½ % solution.

Vagus nerve interference fields emanating from the GI tract usually require more than simple treatment of the interference field. This category may be the cause of the infant colic that is not associated with cranial somatic dysfunction. It is also found in adults, presenting with chronic gastrointestinal disturbances of various kinds. Treatment is avoidance of the foods that are causing the irritation. Food sensitivity testing is often needed to sort this out. I will perhaps write more about this in another newsletter.



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An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

Last month's topic for discussion was the vagus nerve and its potential as an interference field. The fact that 80% of its nerve fibers are afferent was perhaps a surprise to some of us, as the vagus nerves are best known for their parasympathetic function of relaying signals to the thoracic and abdominal viscera. It all seemed so obvious: if vagotomy reduces inflammation in the stomach and other organs, then the effect must be due to the elimination of outgoing (efferent) signals.

More recent research shows that it is not as simple as that. As everywhere in dynamic systems, feedback loops are essential and the vagus nerves are no exception. The function of these vagal afferent fibers is currently receiving a great deal of attention, especially their role in controlling eating behavior. (Understanding the neuro-endocrinology of satiety is becoming an urgent issue, if only to understand epidemic obesity.)

It turns out, vagal afferents transmit a great deal of information from the gut to the regulatory centers in the brain stem. Mechanical and chemical information controlling gut motility, secretion of digestive enzymes, satiety, eating behaviour and even taste preference is mediated by these nerve fibers.

I mentioned in the last newsletter that interference fields in the vagus nerves sometimes indicate food sensitivity. This is a clinical finding that I and other neural therapists have observed. However the neurophysiology of this particular phenomenon is still rudimentary: We do know that vagal afferent fibers penetrate the jejunal mucosa and contact intestinal mucosal mast cells (IMMC) and plasma cells. We also know that electrical stimulation of the vagus results in increased IMMC histamine content. Much more than that is simply not known.

So why is this important in neural therapy? Three reasons:

1. Treatment of a vagus nerve interference field will not be of lasting benefit if the underlying irritation (in this case food sensitivity) is not addressed. The immune-stimulating foods must be identified and eliminated from the diet.
2. Food sensitivities can be such an irritant to the autonomic nervous system (ANS) that it will be "blocked". i.e. it will not respond to autonomic response testing. If the ANS is not performing its regulatory role, the health of the patient suffers.
3. Food sensitivities can provoke or at least contribute to interference fields, not just in the vagus nerves, but also in other structures, especially the viscera.

How do we test for food sensitivities? A variety of methods are available:

1. Autonomic response testing (ART): (See chapter 4 of my book <http://www.neuraltherapybook.com>): First test to see if the patient is regulating. Then place a sample of food near or on the patient and retest. If the response changes from regulating to not-regulating ("blocked") or vice versa, the food is probably provoking some sort of immune response. Alternatively, if an interference field has been found e.g. in the vagus, stomach or liver, the autonomic response when touching that spot will



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change in the presence of a significant food. Be warned: This "rough and ready" method is fraught with potential error. For example, eating too much of a particular food may provoke a false positive response. And a period of elimination may create a false negative. I mostly use this method to screen for the presence of any food sensitivity, using a cluster of food samples representing the common food sensitivities.

2. Vega testing: This "energetic" method has the same drawbacks as ART. However it does allow quick testing for a large number of foods. Like ART it should be used as a rough guide and results confirmed by laboratory testing or a dietary elimination-challenge.
3. Serum IgG testing: A number of labs test for IgG antibodies in the blood to a variety of foods (delayed food sensitivity). This should not be confused with testing for true food allergy, (involving IgE antibodies) usually done by skin prick provocation. IgG testing is especially useful when a number of food sensitivities are present. When large numbers of foods are identified as being reactive, gluten sensitivity is often present.
4. Fecal secretory IgA testing: Stool testing is offered by a few labs and is probably more sensitive than serum IgG testing. However only a limited number of foods are currently evaluated. It is the method of choice in testing for gluten sensitivity.

None of these (or other) methods are fool-proof. However they do provide some guidance in detecting food sensitivities. Food sensitivities resemble neurotoxicity in certain ways. Eliminating dietary triggers not only makes detection of interference fields easier but also makes neural therapy more effective and responses longer lasting.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleague:

If you are a physician and are reading this newsletter, chances are you enjoy practicing medicine. You are curious enough to be looking "outside the box" for a better understanding of what ails your patients and then finding methods of helping them. You probably find that exploring all the possibilities is rewarding and satisfying...perhaps even fun.

I dare say this is not true of all our colleagues. I am now of an age where I see some of my generation retiring - perish the thought! What is it that they don't like about practicing medicine?

Others seem to never lose their passion for practice, (and even more encouraging) their appetite for learning. I know of one physician in particular who could be an example to us all and I would like to use this newsletter to honour him as well as to say something about learning neural therapy.

The physician who I am referring to is Fred Cenaiko MD of Wakaw, Saskatchewan, Canada. Wakaw is a little place in northern Saskatchewan (on Canada's prairies) and Fred has been its only physician for 53 years. This means that he has done all the things that country docs did years ago such as delivering babies, removing gall bladders, setting broken bones, treating medical conditions acute and chronic, fixing sore backs, counseling, etc., as well as serving as town mayor and taking part in church and philanthropic activities. For a short biography, scroll down through this site: <http://www.ucc.sk.ca/programs/nbuilders/2004/index.html>

Fred is a soft-spoken, humble man and rather than embarrass him further by dwelling on his many other accomplishments, I would like to concentrate on reporting those aspects of his life that might be of help to those practicing (or contemplating learning) neural therapy.

Even decades ago, Fred was somewhat of a legend to Canadian prolotherapists, although most of us had never met him. He had been practicing prolotherapy since the 1960's and with the Christian Medical Society made annual trips to Honduras delivering prolotherapy and other medical care to the hinterlands.

Fred was in his late 70's when I first met him; by chance we were sitting side by side on a flight from a medical meeting in Las Vegas. He had been intrigued by a lecture on neural therapy that I had delivered at the conference and he wanted to learn more. Not long after this conversation, he attended one of my two-day seminars and took to neural therapy like a duck to water. He was able to understand and use autonomic response testing almost immediately, even applying it to select the appropriate antibiotic for his patients with bladder infections.

Fred was as excited by his new-found skills as a wet-behind-the-ears medical school graduate. He purchased a Tenscam and was soon identifying and treating interference fields in deep autonomic ganglia. He lives two thousand miles from me but we often have telephone chats during the middle of a practice day discussing



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interesting cases. In fact, here is a report of one of his recent cases:

A 52 year old lady with Ehlers-Danlos Syndrome presented to my office in 1994 walking on her knees. It was rather pathetic to see her in that position. She was treated with prolotherapy injections with some improvement at first. Later this improvement was less noticeable although the patient felt more comfortable after these injections and persisted with the prolotherapy. She was still unable to walk, able only to transfer from wheelchair to bed and vice-versa. In September of 2007, in addition to the usual prolotherapy of the lower thoracic spine and sacroiliac joints, an episiotomy scar was injected with lidocaine. At her next visit in February 2008, she was walking and had started to dance. Further episiotomy scar injections have resulted in continued improvement and she is now walking reasonably long distances. (She had not walked in 20 years). She is overjoyed and is now for the first time able to dance with her sons.

This is a remarkable case by any standard. (I personally have found interference fields in episiotomy scars to be rare). Perhaps as remarkable as the case itself however is the physician who cured this woman. He developed the skills to be able to help her at a stage of his life when many people have been retired for many years.

I am sure that we can all share Dr Cenaiko's satisfaction in this case's outcome and be encouraged to know that the "fun" of learning and practicing medicine can last a life-time.



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NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

You may have noticed that I complain from time to time about the lack of English-language literature on neural therapy. Our inveterate correspondent Rainer Kumm, (a German-trained physician practicing in the UK) regularly reminds me of this by referring me to German and Spanish literature. I am not sure who is the more frustrated by my lack of knowledge of those languages.

As I explained in the introduction to my book *Neural Therapy: Applied neurophysiology and other topics* <http://www.rfkidd.com/booksite/>, my solution to this dilemma has been to go to first principles of science and to build from there. Basic science has been the resource for most of my medical thinking in this area, but even here there are limitations. Not all the important science in the world is published in English!

This is especially true in the realm of biophysics. It seems that German and Russian scientists have published a great deal in their own languages. Whether this is due to a lack of interest in the subject in the English speaking world, difficulty finding good translators, or simply choosing to write for the largest existing audience, it is hard to say.

About 25 years ago a monograph summarizing many years of work by a group of Austrian researchers was translated into English. The title of the book was "The Extracellular Matrix and Ground Regulation". The subject matter was the anatomy and physiology of the extracellular space. The book's author was Alfred Pischinger.

This marvelous little book was important for two reasons: (1) It was a systematic study of a neglected subject - the "matrix" or extracellular space. (2) It was a window (through the language barrier) into the German-speaking world of science and medicine.

This book has been one of my most treasured possessions for over 20 years. I have gone back to it often and you will notice many references to it in my book on neural therapy. You can imagine my excitement at the news that a translation of the (new) German 10th edition is now available.

Alfred Pischinger passed away in 1982 so this edition is edited by a colleague, Hartmut Heine; - at least that is what is stated on the cover. However examination of the contents shows three editors, one for each of its three sections. The first section is by Heine and covers the structure and function of the extracellular space. The second (by Bergsmann) covers regulatory control of the "ground system" found in this space. The third (by Perger) is about "therapeutic consequences" of matrix regulation research.

Information about neural therapy (and acupuncture) is scattered throughout the book. In the first section, the structure and function of proteoglycans and structural glycoproteins is covered in a general way. It is fascinating to read how the bottle-brush structure of proteoglycan molecules interplay with crystalline water. And how the glycocalyx (the sugar surface of cells and other intercellular components) transmits information through the extracellular space and through the cell membranes. All these



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molecules are negatively charged and electrically very active. The proteoglycans in particular, have piezo-electric properties, respond to mechanical as well electrical forces, and act as a sieve, permitting or preventing the passage of large protein molecules according to circumstances. The clinical recognition of the importance of adequate hydration makes more sense when the physiology of this space is understood. In addition, the matrix's electrical properties support the idea that information can be spread rapidly throughout the body independently of the nervous system.

The second section includes a brief tutorial on cybernetics, i.e. feedback loops and regulatory principles. Neural therapy has sometimes been referred to as "regulation therapy" and this part explains why. It is especially useful in explaining the limits of neural therapy and why it often does not work when the ground system (and the autonomic nervous system) is "blocked". The anatomy and physiology of acupuncture points is covered. Acupuncture points are described as "windows" into the extracellular matrix. Palpation of these points is recommended as a method of evaluating the condition of the underlying extracellular tissue.

The third section describes the famous "puncture phenomenon" discovered by Pischinger in the 1970s. Skin puncture was shown to provoke changes in venous pH, oxygen saturation, electrolytes, cholesterol, leukocytes, etc., lasting up to five days, especially on the ipsilateral side of the body. Because these changes are measurable on the venous side only, a disturbance in matrix regulation is the obvious cause. Iodometry, a technique of measuring iodine consumption of the blood and thus the concentration of oxidants (such as free radicals) was developed to assess the reactivity of the ground system. This method has been used to demonstrate that the outcome of all treatments, from neural therapy to surgery and chemotherapy, is affected by the pre-existing state of the matrix.

I was intrigued to find that the state of the gut has been recognized to have a major effect on the body's ability to regulate. There was an inkling of this idea in the last edition, but considerable new research is presented to flesh this concept out.

The organization of this edition is improved over the last one. The writing and translation are better in the first two sections, but strangely, not in the last. It would have been helpful had trade names of some medications and German diagnostic procedures and protocols been explained for English speaking readers.

This book is nevertheless a treasure - highly recommended for all physicians, and especially those interested in neural therapy.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

Have you heard of "oral allergy syndrome"? I must admit I had not, - until earlier this year when a 16 year old girl (I'll call her Cindy) appeared in my office with her mother. The diagnosis had already been made by an allergist and treatment had been started – antihistamines and avoidance of a long list of foods, mostly raw fruits and vegetables. However the dietary restrictions were severe; Cindy had become "paranoid" about her food; and her mother was concerned that her nutrition was suffering. Indeed, a previously athletic and energetic young woman had lost her spark and needed to take naps after school.

A quick internet search taught me that oral allergy syndrome is not rare and is in fact common among those with pollen allergy (up to 70%). The odd thing about it is that allergic symptoms (itching, burning or tingling) are confined to the lips, mouth and throat. Contact with a variety of usually only raw foods is the trigger. Typically symptoms are mild and do not last for more than a few minutes.

Cindy had experienced some mild itching in her mouth while eating apples and almonds since age 10. However, three months before her attendance at my office, she had undergone a sudden, severe, anaphylactic reaction when eating raw celery. Her symptoms were reduced by taking an antihistamine, but a few days later she had another severe reaction. Since then she was reacting even to cooked foods and was understandably quite frightened.

The questions that formed in my mind were: Why should these relatively mild allergic symptoms have suddenly become so severe? Had a regulatory control gone awry, and if so, where and why?

Everyone practicing neural therapy knows that the first step in solving these problems is to question the patient about trauma, illness, surgical procedures, vaccination, dental work or emotional upset occurring in the weeks or months preceding the onset of the illness. In Cindy's case three possible events came up in her story:

1. Infectious mononucleosis 7 months before. (Cindy missed one month of school because of her illness and complained of more fatigue and "colds" from that time.)
2. Hepatitis vaccination 6 months before (yes, just a month after the beginning of the mono).
3. Intradermal allergy testing 3 months before.

Cindy looked well and her general examination was non-contributory. Autonomic response testing showed a "therapy localization" sign (an indication that an important interference field was present somewhere in the body). This turned out to be the liver which was treated by "segmental therapy" (intradermal procaine injections followed by an intravenous bolus).

The result was a noticeable improvement in her symptoms for a few days. She was able



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For neural therapy and advanced healing



to eat cooked spinach with only a mild reaction. On her next visit autonomic response testing showed no liver interference field, but rather one in the right tonsillar area, which reacted to a high potency homeopathic of "silberamalgam". (Reaction to this homeopathic usually means a marked sensitivity to mercury - typically from dental amalgam or from a Thimerosal preservative in a vaccine, such as that for hepatitis). The right tonsil was treated with an injection of dilute procaine followed by an intravenous bolus. Blocked regulation persisted, but autonomic response testing then showed an interference field in the large intestine which turned out to be predominately psychosomatic. (See chapter 11 of Neural therapy: Applied neurophysiology and other topics available at <http://www.neuraltherapybook.com>.) An applied psychoneurobiology technique using coloured glasses and eye movement desensitization as described in this chapter then resulted in open (or "unblocked") regulation.

The response was dramatic. Within a few days, Cindy was eating a variety of foods that she had avoided for months. However autonomic response testing showed blocked regulation and a continuing very strong reaction to silberamalgam. As she had no dental amalgam, this reaction suggested that the Thimerosal in the hepatitis vaccine had been a contributor to her exaggerated oral allergy syndrome. She was prescribed a detoxification program to facilitate excretion of mercury, centering mostly on chlorella and vitamin C. Two further follow-up visits revealed continuing improvement although she was still too frightened to try the raw foods that she had not been able to tolerate initially. Cindy is now away studying at university, so it will be some time before we learn how far she progresses.

In retrospect, it is likely that a number of factors contributed to her allergy exacerbation: The initial interference field in the liver might have been triggered by the hepatitis vaccine and/or the infectious mononucleosis. The second interference field in the tonsil was likely a residual of the infectious mono. The third (psychogenic) interference field in the bowel possibly reflected her rather "driven" type A personality. (Her long term goal is medical school!) And finally, the mercury from the Thimerosal could well have sensitized her immune system.

In any case, this situation demonstrates how immune and autonomic nervous system functioning are intertwined. The autonomic nervous system component in any allergic condition should be searched for and treated if an interference field is found, no matter where in the body.



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NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of Neural Therapy: Applied Neurophysiology and Other Topics

Dear Colleagues:

This month I would like to discuss the retrobulbar (or ciliary) ganglion. Actually, ciliary ganglion is the more commonly used term, but I like the retrobulbar name, partly because it describes its location so well, but also because it avoids confusion with the similarly sounding "celiac plexus". For ophthalmologists that is not a problem, but for those of us occupied with whole-body medicine, we don't want to confuse the two.

The retrobulbar ganglion is one of the smallest of the named ganglia - about the size of a pinhead and situated in the back of the orbit. It is one of four parasympathetic ganglia on each side of the head, the others being the sphenopalatine (pterygopalatine), otic and submandibular ganglia. An excellent diagram and description of the retrobulbar neuroanatomy can be found at:

<http://www.medrounds.org/ocular-pathology-study-guide/2006/03/where-is-ciliary-ganglion.html>

It is the parasympathetic control of the anterior eye muscles that is of most interest to the clinician. In Adie's syndrome, ciliary ganglion disease produces a fixed pupil, unresponsive to light but able to accommodate to near vision. Most of the time this syndrome is idiopathic. However the ganglion can also be injured by surgical repair of orbital fractures.

For the physician practicing neural therapy, the retrobulbar ganglia are interesting for another reason. Interference fields in the retrobulbar ganglia are not rare and can cause problems far removed from the eyes! Physical examination of the eyes usually provides no clue as to their presence.

These two cases presented in my office this year:

A very active and physically fit woman of 50 (who works with her husband as a logger!) presented with low back pain of 1.5 years duration. The pain was not disabling, but her low back ached, sometimes felt warm and was exacerbated by forward bending. At times pain radiated into her groin and posterior legs to her feet. There was no immediately preceding trauma or strain but she had hurt her back in a fall 5 years before and a year after that had an episode of low back pain lasting a few weeks. Past surgery included partial hysterectomy at age 35 and PRK (laser vision correction or photorefractory keratectomy) two years before.

No lasting relief from her back pain had been obtained by manipulation, intramuscular (needle) stimulation, prolotherapy or caudal epidural block. Her health was otherwise good.

Musculoskeletal examination showed relatively good body symmetry, muscle balance and range of low back movement. Autonomic response testing revealed an interference field behind the left eye. This was treated with a Tenscam device resulting in abolition of the interference field and restoration of previously blocked regulation. The next day the low back pain disappeared. Except for a short lasting relapse after a fall a few weeks later, the patient has been pain-free for seven months.



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A 54 year old man presented with chronic low back pain of 8 years duration. The pain began with a motor vehicle accident and was exacerbated by a second accident a year later. In both accidents he was thrown forward torquing his trunk around the diagonally placed belt across his chest. Within a few weeks of the second accident, pain began to develop in his left groin, medial thigh and calf, with numbness in his foot. In the ensuing years a similar pain began to develop in the right leg as well.

Previous trauma included lacerations of this right wrist 17 years before, requiring surgical repair. His only other surgery was correction of a "lazy eye" at age 16. Medical problems included cigarette addiction, recurring pneumonia, depression and fatigue.

Examination of his musculoskeletal system showed considerable asymmetry, muscle imbalance and muscle tightness. The most important of many somatic dysfunctions was an "oscillating" right sacral shear, i.e. a sacrum that oscillated between positions of shear and neutral in synchrony with the craniosacral (primary respiratory) rhythm. This was treated using an osteopathic unwinding technique. Two weeks later he reported that he felt "like a truck had run over (me)"; then an overall improvement. On his second visit he was again treated by manipulation - of his left foot, pelvic floor and cranium. This resulted in a shift in location of pain, but no improvement. At this point a search for interference fields was begun, especially of the lungs, teeth and surgical scars. A "therapy localization sign" (see page 51 of <http://www.neuraltherapybook.com>) was found on the left side and an interference field in the left retrobulbar ganglion area. This was treated with the Tenscam. On the next visit he reported that he had "got a lot better".

In the ensuing months, he followed an up-and-down course. His fatigue and depression were investigated and were treated (mostly by nutrition). The retrobulbar ganglion required a second treatment 3 months later but overall his progress has been in a positive direction.

In both of these cases, an interference field in a retrobulbar ganglion played a significant role in generating chronic low back pain. In the first, the more simple one, the interference field developed in a classical manner as a result of PRK. As the popularity of laser vision correction increases, we will need to be on the lookout for this.

The second case was more complex. Eye surgery had been performed many years before the onset of the back pain. And clearly injuries from the two motor vehicle accidents had played important roles. However, the retrobulbar interference field had no doubt been present "below the surface" all along. Its identification and treatment made a big difference in this case's positive outcome.

The moral to these stories is that interference fields can be found anywhere! And a careful, detailed history is essential for knowing where to look.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

A recent newspaper report on "nanoscaffolding" for regrowth of severed limbs or other tissue caught my eye. The headline read: "U.S. military can regrow human limbs, organs"

<http://www.canada.com/montrealgazette/news/story.html?id=6864c9e0-cfcc-4cf6-b373-6d4cbabe6cd3>.

According to the newspaper description, the nanoscaffolding was made of tiny polymer fibers on which human cells grew, like vines on a trellis. The technology has already succeeded in re-growing severed fingertips and skin over third degree burns.

Exciting stuff! This topic brought back to my memory Becker and Selden's classic book "The Body Electric" published in 1985. The book makes available to laymen Becker's 30 years of research into the effects of electricity and magnetism on biological growth and repair. Becker was fascinated by the salamander's ability to re-grow severed limbs and discovered that electrical currents are a vital part of the repair process in not only reptiles, but also in mammals. Also electrical forces were found to be critical to directing growth in the normal process of physical maturation. Becker applied this knowledge to solve the ancient problem of fracture non-union. By applying minute currents through the fracture site, bone growth was stimulated and fractures healed. This technique has since become standard orthopaedic treatment throughout the world.

I can find no mention in Becker's book of the effect of procaine on delayed or non-union of fractures. Yet as far back as 1928, Leriche, one of the great scientist-clinicians of the early 1900's, recommended procaine injections into the fracture site to improve circulation and callus formation in cases of delayed union. Dosch recommends its use even in fresh fractures to facilitate healing, on the basis of results from animal research. As far as I know, the neural therapy pioneers had only the vaguest of ideas of how procaine could affect the physiology of wound healing. They knew that procaine restores cell membrane electrical potentials and improves circulation, but they do not seem to have studied its effect on "current of injury", a phenomenon discovered in the early 1800's and later recognized by Becker as a key to understanding wound healing.

As clinicians I suppose we don't need to know exactly how things work before applying them to the problems we face. Neural therapy is ultimately an empirical art. A case I saw in my practice demonstrates this.

An otherwise healthy 52 year old woman slipped on ice-covered stairs and fell, landing on her shoulder. She sustained a sub-capital humeral fracture and was treated with a sling. Four weeks after the injury she was still in considerable pain and a repeat Xray showed no sign of healing.

It was at this point she presented in my office. The fracture site was tender to palpation, warm and slightly swollen. Autonomic response testing revealed an interference field at the fracture site. I elected to treat the interference field with the Tenscam device, rather than the usual subcutaneous blebs of dilute procaine recommended in classical neural therapy. The response was immediate - a significant reduction in pain. The pain



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relief proved to be lasting and a repeat Xray taken a week later showed new callus formation. The fracture continued to heal in a normal way without further treatment.

Neural therapy can be used in delayed healing not only of fractures, but also of any wound. Persisting pain and swelling of sprains respond quickly to treatment (See Volume 1, No. 9 of <http://www.neuraltherapybook.com/newsletters/>), as do skin ulcers or lacerations.

On a slightly different topic, the suggestion has been made that fresh surgical wounds should be irrigated with dilute procaine to improve healing and to prevent infection. A controlled study mentioned by Dosch (p. 241 of the more recent textbook, p. 299 of the old one) showed reduced post-operative pain with administration of procaine at the time of surgery. This is of course not the same thing as preventing infection. I could find nothing in the English literature (using a Pubmed search) to support the idea, and in fact I found one 1980 study showing delayed initial healing when a fresh wound was infiltrated with 2% procaine. Perhaps our Russian and/or German speaking readers could help us out in this area!

Personally, I am loathe to interfere with nature's good work, unless the natural process of healing seems to be interrupted or delayed. Just as anti-inflammatory medications do not make sense to me in acute illness or injury, (when inflammation is doing its intended job), I feel that procaine should be reserved for those instances when nature is not doing its proper work. Procaine (as also the Tenscam) regulates the body's neurological control mechanisms. It works with nature; it does not replace it.



NEURAL THERAPY IN PRACTICE

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Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

I am often asked, "How do neural therapy and acupuncture compare?" - a fair question, but not an easy one to answer. The main difficulty is that they are similar in some respects, but different in many others.

Both systems lie outside the medical mainstream; both use needles and both achieve results where "conventional" medicine has reached its limit. But beyond these similarities lie some big differences.

Acupuncture derives from a four thousand year old medical tradition, rich in clinical observation, but (until recently) devoid of what we in the West would call a scientific basis. Neural therapy is only decades old and right from its beginning has been an offspring of Western physiology, anatomy and biophysics.

Despite these similarities and differences, there are areas in which the two systems overlap. It did not take long for neural therapists to discover that injecting procaine into certain acupuncture points had powerful remote effects. For example Yintang (Extra 1) and Zanzhu (U.B. 2) (points between the eyebrows), and Hegu (L.I.4) in the thenar eminence are used in treating facial sinus interference fields. And in the 1950s Voll (using galvanometric measurements) discovered that each tooth lies on an acupuncture meridian and that neural therapy of the tooth can treat organs and structures along that meridian.

Those using autonomic response testing know that touching an active acupuncture point will trigger an autonomic response (weakening or strengthening of an indicator muscle). In the case of Zhongfu (lung 1), an "alarm point", an autonomic response indicates that the lung itself is an interference field.

Western anatomical study of the acupuncture point has demonstrated that it is a real structure, a "window" through the dermis connecting the extracellular space or matrix, with the outside world. It is richly supplied with autonomic nerve fibers, thus suggesting that one of the effects of acupuncture could be to stimulate the autonomic nervous system.

Also the effect of the needle puncture itself, quite apart from the procaine injection, was shown in the 1970s by Pischinger to have effects on systemic biochemistry lasting days (the "puncture effect"). Could it be that at times neural therapists are accidentally and unknowingly practicing acupuncture?

Be that as it may, there are times when neural therapy succeeds where acupuncture fails, and other times when acupuncture succeeds where neural therapy has failed. In any case, the neural therapist makes a good investment in time to learn at least some acupuncture.

One area of acupuncture theory of practical value to the neural therapist is the location of the acupuncture meridians. It is not necessary to memorize every point,



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but a good general knowledge pays dividends. For example, the stomach meridians cross the cheeks, more or less in the area where one finds rosacea. Rosacea has more than one cause, but stomach trouble, especially hypochlorhydria is one of them.

Pain can sometimes be felt along an acupuncture meridian or in a specific spot corresponding to an interference field in the organ of that meridian. Unexplained leg pains can sometimes be traced along a path indicating interference fields in the liver or gall bladder. I have seen pain corresponding to the bizarre zigzag pattern of the gall bladder meridian on the side of the head.

Recently a patient presented in my office with pain at the base of her first metacarpal. Pain in this area, especially if it is bilateral, is sometimes caused by a stomach problem, (perhaps referral to the C6 dermatome?). However in this case the patient had an interference field in the ipsilateral lung. (The painful spot in the wrist was near Taiyuan, lung 9). Neural therapy of the lung produced immediate relief of the wrist pain. Repeat sessions cured it.

Another interesting case involving a lung acupuncture point was a patient with constant shoulder pain precipitated by a steroid injection into the shoulder joint. My first thought was that the puncture site itself (an anterior approach) was an interference field, as autonomic response testing over the injection site was positive. However neural therapy of the injection site gave indifferent results. It was then I wondered if the autonomic response might have something to do with the lung, as it coincided more or less with acupuncture point Zhongfu (Lung1). Neural therapy of the lung gave instant relief of the shoulder pain.

My knowledge of acupuncture is quite limited and I suspect many of my readers could say more about the interconnections of neural therapy and acupuncture than I can. However I offer these observations simply as an encouragement for readers to be alert to the possibilities of combining perspectives from different medical traditions. As always, comments (and corrections) from readers are welcome.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

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Dear Colleagues:

Last month I made mention of the lung and its connection with the lung meridians as identified in acupuncture. This month I would like to consider the subject of the lung as an interference field in more general terms. The lung is easily overlooked, as the symptoms produced by lung interference fields often do not relate to lung symptoms at all. Lung interference fields can cause pain syndromes, fatigue or other symptoms without any cough, shortness of breath or other sign of lung problems.

Of course this is true of other organ interference fields as well. The key is always to look for an illness, trauma, or surgical or dental procedure in the weeks or months before the onset of the patient's symptoms. There is usually a latent period, long enough that neither patient nor physician makes the causative connection.

Lung interference fields may be unilateral or bilateral. When they are unilateral, non-respiratory symptoms are usually (but not always) on the same side. If you are able to identify the interference field with autonomic response testing or some other method, treatment of only one side is necessary. If the identification is made by history alone, there is no reason not to treat both sides.

I remember finding a lung interference field in a middle-aged man with chronic fatigue syndrome. He had had pneumonia many years before and "had never been right since". Neural therapy of the lung immediately improved his energy level. Although attention to nutritional and other factors was necessary as well, repeat neural therapy treatments over several months resulted in a cure of his chronic fatigue syndrome.

The patient who has asthma, chronic cough or recurring bouts of pneumonia over the years often has a lung interference field. Neural therapy can "cure" asthma, put an end to chronic cough in some of these patients and prevent recurrence of pneumonia. It is particularly effective in treating pleurisy.

I suspect that most readers of this newsletter (like I) deal mainly with chronic medical conditions. And for that reason we do not often have the opportunity to manage acute illness. In one respect this is a shame, as neural therapy is a very effective treatment for a potentially serious acute illness i.e. pneumonia. In pre-antibiotic days, pneumonia was a killer of young people as well as of old.

Imagine then the impact of this report that came out of the old Soviet Union in 1944: (Speransky AD: Experimental and clinical lobar pneumonia. *Am. Rev. Soviet Med.* 2:22-27, Oct. 1944). This paper was remarkable in a number respects: It described a simple and effective treatment for pneumonia in the most challenging of circumstances - the malnutrition, crowding, poor hygiene and stress of wartime. In addition, the report was written by AD Speransky, the famous Russian neurophysiologist, who in the 1920s and 1930s headed one of the greatest physiological research institutes in the world. His landmark book: *Basis for a theory*



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of medicine had been published in 1935, just before the Stalinist purges that destroyed so many of the Soviet Union's finest researchers, intellectuals and others. Reading the English-speaking research literature, it seemed as if Speransky had disappeared, but here he resurfaces, applying theoretical knowledge from his research laboratories!

The technique that Speransky used was to inject large volumes of dilute procaine intradermally into a diamond-shaped area extending sagittally from C3 to T4 and covering the medial halves of the scapulae. Typically the fever vanished within 18 to 24 hours and the patient recovered quickly afterward. This sounds remarkably like the neural therapy that was being developed independently and concurrently in Germany.

Korr was aware of this article and emphasized its importance to the American Osteopathic Association at their annual conference in 1948. He recognized that the segments that Speransky was injecting with procaine were the same that the osteopaths were manipulating and that the therapeutic mechanisms were probably identical.

This simple and inexpensive treatment of pneumonia was soon overshadowed by the newly discovered antibiotics that were then becoming available. Antibiotics have for over 60 years become the gold standard, but new conditions may be inviting neural therapy to make a return to the stage. Speransky's studies showed the response to treatment was independent of the species of pathogen. It is therefore likely that otherwise untreatable viral pneumonia responds to neural therapy. (I have treated too few cases personally to make general statements about its efficacy).

A second, not to be overlooked benefit of neural therapy is its cheapness. And probably most important of all is its independence from the growing problem of antibiotic resistance.

Neural therapy can be used in treatment of acute illnesses as well as chronic. Pneumonia is the acute illness where its efficacy is the most dramatic and the best documented. As always, I am interested in comments from readers who have had direct experience in treating pneumonia by neural therapy.



NEURAL THERAPY IN PRACTICE

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Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

I wonder if you find pain patterns as interesting as I do? This is a subject that first drew me to *orthopaedic medicine*, the late James Cyriax's system of identifying the precise anatomical locations generating musculoskeletal pain. In addition to his method of "systematic examination of the moving parts by selective tension" he also showed that musculoskeletal pain refers from specific structures in predictable patterns.

A knowledge of anatomy was the key. For example, pain referring down from the shoulder joint, i.e. in a C5 dermatomal pattern would have to be coming from a glenohumeral structure - joint, bursa or tendon. On the other hand, pain referring upward, to the upper shoulder or lower lateral neck would have to be coming from the acromioclavicular joint as it receives C4 innervation.

The systematic study of referred pain began long ago - in the 1800s. Surgeons already knew that pain could be referred from inflamed organs. Then in the late 1800s British neurologist Sir Henry Head demonstrated that referred pain from organs followed the body's ontogenetic segments in a systematic way. To this day these patterns are called "Head zones".

Kjellgren's experiments in the 1930s, using injections of hypertonic solutions into muscles, ligaments and peritoneum demonstrated referral of pain from somatic structures. Janet Travel refined this work by studying muscle trigger points. Using injections of local anesthetic, she showed that myofascial pain syndromes could be diagnosed and treated by identifying and injecting the corresponding trigger points. Her two-volume textbook *Myofascial pain and dysfunction: The trigger point manual* (now revised and updated by David Simons) remains the standard reference on this subject.

George Hackett, a Cleveland trauma surgeon, did similar work in the 1940s and 50s on ligament trigger points. He demonstrated that ligaments stabilizing the pelvic ring and lumbar spine were common generators of referred pain (in consistent patterns for each ligament) into the groin, hip and/or down the leg. Hackett went on to become one of the pioneers of prolotherapy (or sclerotherapy), a method of treating ligament "laxity" and pain by injecting "proliferating" solutions such as dextrose into fibro-osseous junctions.

Pain referral patterns overlap from muscle trigger points, ligament trigger points, and no doubt from injured periosteum. It is interesting how pain from adjacent or related somatic structures can refer in similar ways. Notice the similar referral patterns of two phylogenetically related structures: the ilio-lumbar ligament and the inferior quadratus lumborum muscle.

How can knowledge of these patterns help the neural therapist? A recent case presenting in my office shows how:



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An otherwise healthy 55 year-old operating room nurse presented with right inferior heel pain of 6 months duration. This pain had developed during recovery from a fracture of her ipsilateral posterior ramus of the ischium. It was similar to a chronic pain in the heel she had experienced for a few years 25 years earlier. In the previous episode the heel pain had settled with the help of foot orthotics.

With the help of autonomic response testing, an interference field was detected at the site of the pelvic fracture. However neural therapy (with the Tenscam) produced no lasting benefit. Because of the history of a similar heel pain 25 years previously, the foot region was also searched for interference fields. One was found over a two-inch portion of the distal Achilles tendon. Neural therapy of this spot produced pain relief lasting a few days. However repeat neural therapy of not only the Achilles tendon but also the pelvic fracture site was needed for a cure of the chronic heel pain.

As so often happens in office-based clinical medicine, one can only speculate as to the mechanisms of these pain patterns. Here is my theory:

A sub-threshold memory of the 25 years old pain i.e. "tissue memory" was present (in the tissues or in the central nervous system). The pelvic fracture was anatomically very close to the part of the ischium to which the sacro-tuberous ligament attaches. Hackett's work showed that sacrotuberous ligament pain refers to the inferior aspect of the heel. Presumably adjacent periosteum refers in a similar way.

I suspect that this woman's heel pain was a result of summation of two sub-threshold pain experiences, leading to an element of neurogenic inflammation. If summation were the only process in play, treatment of the pelvic fracture interference field should have reduced the afferent neurological input to below threshold level again, thus eliminating the pain. However, it did not, and neural therapy of both interference fields was necessary to achieve lasting pain relief.

In my experience pain referral patterns frequently do not follow the classical patterns described in the textbooks. This is because so often more than one "pain generator" is present. Understanding this concept is invaluable in successfully treating our patients with neural therapy.



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Dear Colleagues:

This month I would like to bring up the subject of unintended harm (by physicians) to their patients and how it relates to neural therapy. Iatrogenic is the term we use to describe it.

When we think of iatrogenic illness, we usually consider adverse effects of medications, complications of surgery, or other treatments that have gone awry. However with increasing dependence on technology for diagnosis, we also need to be alert to iatrogenic illness caused by diagnostic procedures.

We are all aware of allergic reactions to radio-contrast dyes. The reactions are immediate and the connection is obvious. Less well known is reaction to the magnetic fields of MRI imaging. I have seen two cases in my practice in the last year of severe chronic illness being precipitated by an MRI scan. In one of these the reaction was clearly that of a "second blow" as described by Speransky, i.e. an irritation of the nervous system awakening a tissue memory of an older experience (of disease or dysfunction). The other was a straightforward "burn", or induction of an abnormal electrical current within the patient's body. I suspect, but cannot prove that this occurs in patients with pre-existing interference fields. (*Reports or comments on this subject from the readership would be welcomed*).

I have already written on interference fields caused by injections, often vaccinations. These reactions are more subtle, as the adverse effect usually does not appear until weeks later, and the connection is rarely made by patient or physician.

Any penetration of the patient's skin can create an interference field and this holds true of diagnostic procedures as well. Even experienced neural therapists can miss these, as the procedure is often only a minor event during a period of acute illness, or in the course of a chronic one.

I have seen two cases in which a pain syndrome developed weeks after investigation of suspected coronary artery disease. In one case the patient (a 50 year old male) developed left carpal tunnel syndrome. In the other, (a 73 year old male) developed heel pain and ankle oedema. My first suspicion in both cases was that the pain arose from an interference field connected with the heart, perhaps the heart itself or even a stellate ganglion. However with autonomic response testing, nothing could be found in these areas. It was only after considering that coronary angiography had been performed that the site of insertion of the arterial catheter in the groin (in the right femoral artery) was checked. In both cases neural therapy of the catheterization site resolved the pain problems.

A recent case of bilateral facial pain turned out also to be of iatrogenic origin. A healthy 38 year old woman had a minor gynecological procedure performed under general anaesthetic. A few weeks later she developed facial pain. Her dental health was excellent and she had no history of facial sinus problems. I suspected trauma during intubation, but nothing could be found on general examination. Interference



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fields were searched for by autonomic response testing in the oro-pharynx and a positive response was obtained for the adenoids (weakening of an indicator muscle when the tip of the tongue was placed at the junction of the hard and soft palates in the midline). Neural therapy of the adenoids resulted in only minor improvement on follow-up three weeks later.

It was then that the palate was examined more carefully, and the right palatine bone was discovered to be slightly displaced relative to the left. Cranial manipulation using direct technique released the palatine and the patient's pain subsided significantly.

No doubt there are many other ways in which interference fields can accidentally be created during investigations. Again reports from the readership on this subject would be appreciated.

The next issue will mark the beginning of our fourth year of neural therapy newsletters. (For those of you who have only recently signed on, an archive is available at: <http://www.neuraltherapybook.com/newsletters/>).

I have found this to be a rewarding project, mostly because of letters from interesting people from all parts of the world. The readership includes physicians (and others) from every continent - except Antarctica. I particularly value correspondence from German and Spanish speaking neural therapists, even though they often struggle to express themselves in English. From what I understand, neural therapy is best established in the countries that speak these languages. No doubt they have much to teach their English-speaking colleagues! Here is a recent example:

Dear Dr Kidd,

I am an orthopedic surgeon from Ecuador. Sorry my written English is not very good. I like neural therapy a lot. I have been working with it for 8 years. And I have written two articles: on RSD (reflex sympathetic dystrophy) and neural therapy, and on neck pain and neural therapy. They are written in Spanish.

I like the term "tissue memory". Everything is going to end in "information". Not everything is energy and mass; there is also information and conscience. What I see many times in my practice is how trauma awakens interference fields. That is what Speransky called the "second hit". Probably we should keep this in mind when working with pain therapies.

Thank you for your letters.

Sincerely yours,
Dr. Carlos Chiriboga



NEURAL THERAPY IN PRACTICE

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Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

I suppose we all know what the term "irritable bladder" means. It is one of those expressions that is neither symptom nor diagnosis, but which we employ to describe a constellation of symptoms. The term overlaps with many others - bladder instability, overactive bladder, painful bladder syndrome, interstitial cystitis, urge incontinence, etc. Of course within these terms exists a spectrum of symptoms, from a mild increase in the frequency of urination to incontinence and severe pain on voiding.

Theories abound as to causes. Urodynamic studies show that sensory urgency, detrusor overactivity, hypotonic urethra, hyporeactivity of sphincter musculature, and involuntary relaxation of the urethra all occur - in isolation or in combination. Altered mechanics such as prolapse (of uterus and/or vagina) or prostatic hypertrophy no doubt often play a role. Jonathon Wright teaches that enuresis in children is usually related to food sensitivities: "asthma of the bladder". The Interstitial Cystitis Association advises its members to identify dietary "triggers" that exacerbate symptoms. A good collection of abstracts on the above subjects can be found at their website

at: <http://www.ichelp.org/ResearchCenter/LiteratureReview/tabid/409/Default.aspx>

Where does the autonomic nervous system fit into this discussion? -
(the first question of the neural therapist!)

Anatomically, we know that the bladder receives both parasympathetic and sympathetic innervation. Parasympathetic fibers cause contraction of the detrusor muscle and relaxation of the trigone and urethra thereby facilitating voiding. Sympathetic fibers also innervate the bladder wall, but have opposite effects. They cause relaxation of the detrusor and contraction of the trigone - important in allowing filling of the bladder. In addition, sympathetic fibers modulate activity in the parasympathetic ganglia embedded in the bladder wall.

One clue relating the autonomic nervous system to bladder irritability is the common association of irritable bladder with irritable bowel syndrome. Although other mechanisms may also explain this relationship, it seems likely that ANS disturbance is the common factor.

The osteopathic profession has long recognized bladder irritability to be related to somatic dysfunction of the pelvis, especially of the pubes. These can be treated quite simply by manipulation.

In neural therapy, bladder irritability is often found to be related to an interference field in the bladder itself or to a kidney or a lower thoracic sympathetic ganglion. Scars or incisor teeth are other possibilities. I have found quaddles injected over the bladder area to be quite effective when the interference field is in the bladder. Dosch's textbook also recommends quaddles over the sacrum, injections into the bladder neck through the abdominal wall to behind the pubes, paraurethral injections



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through the anterior vaginal wall, and injections of the prostate capsule, pelvic plexus, or presacral ganglia.

Having said that, I have found that the more severe cases of interstitial cystitis do not respond lastingly to neural therapy alone. However some encouraging reports have appeared in the literature of responses to bladder irrigation with procaine in combination with alkalinizing agents and other substances.

It is interesting that electrostimulation using a variety of techniques and frequencies, (from 5 to 50 Hz) has been shown to be effective in a large number of trials. I cannot help but notice the resemblance to neural therapy, using the Tenscam device. The Tenscam delivers an 8 Hz "energy" (neither electrical nor magnetic) and seems to have similar effects to that of procaine. So it would seem that the electrostimulation is working in a similar way to neural therapy i.e. modulating and regulating the autonomic nervous system



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

The prolific American-Japanese engineer, surgeon, scientist and acupuncturist Yoshiaki Omura is a proponent of what he calls "selective drug uptake enhancement" using acupuncture techniques. The idea of "drug uptake enhancement" acknowledges the fact that the very organs that need drug therapy generally have impaired circulation; i.e. the drugs given to treat an organ or tissue can't get there. Just as an abscess "walls off" infection to protect the organism as a whole, so also does the autonomic nervous system reduce blood flow to organs or tissues to limit the spread of damage.

The idea of improving circulation to a dysfunctional organ or tissue is an underlying goal of neural therapy. The same could be said of osteopathy and a number of other non-mainstream medical approaches. Drugs are not usually part of the treatment plan, but there is no reason that they could not be used under some circumstances.

However there are circumstances in which improving circulation through an organ or tissue is not in the patient's best interest. This occurs when an organ is carrying a toxic load which (when released) is more than the patient's excretory ability can handle. The stereotypical example is the bone and soft tissues of the face in the patient who has (or has had) dental amalgam fillings.

Dental literature dating back to the 1950's documents the amalgam-periodontal disease connection. Not only does mercury accumulate in the kidneys, liver, pancreas, etc, but also in the nearby tissues of the oral mucosa, periodontal connective tissue and alveolar bone of the jaw and maxilla.

The neural therapist needs to be aware of this when doing neural therapy in the mouth and facial sinus regions. Neural therapy by its very nature opens up circulation and mobilizes mercury from these tissues. This may be therapeutic for the target tissues, but also can shift the toxic burden to the excretory organs, especially the kidneys and liver.

If after performing a sphenopalatine ganglion injection, the patient begins to experience fatigue, malaise, headache, etc. one should look for interference fields in the kidneys or liver. There may well have been a shift of mercury from the tissues of the face to one of these excretory organs. Neural therapy of the affected organ can provide immediate relief.

An illustrative case: A 52 year old woman presented with chronic fatigue, headaches and mild depression of a few years' duration. She was diagnosed with chronic mercury poisoning from her amalgam fillings and was treated over a period of several months with nutritional support, amalgam filling replacement and intravenous DMPS chelation. Urinary excretion of mercury was monitored after every third DMPS chelation treatment. As the mercury excretion decreased to almost zero, so also did her energy and other symptoms improve to the point that treatment was concluded.



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A few months later she returned with a sudden relapse of her symptoms. This occurred soon after elective oral surgery. A repeat DMPS challenge yielded a urinary excretion of over 70 micrograms of mercury per gram of creatinine - a very high level in any patient with chronic mercury poisoning.

Although this sudden increase in mercury excretion could not be blamed on neural therapy per se, the best explanation for the relapse is that mercury was mobilized from the periodontal tissues by the surgery, by the local anaesthetic injections or by a combination of both. In either case, the mercury must have come from the peri-oral tissues.

This is of course not a reason to avoid neural therapy in the face and dental regions. It is simply a precautionary tale so that the physician can identify and treat this occasional complication of neural therapy.

Letter:
Dr. Kidd:

In response to your request for MRI related pathology - I may have seen a case of a therapeutic MRI:

I had a patient - female, mid 40's - who I was seeing for mixed-type Migraine cephalgia. Her history was that the headaches started after she was shocked by a high voltage line at work. She also had several severe accidents/traumas in her past and has a hyper-alert type personality, and always resembled a wild animal ready to bolt out the door at any moment.

As part of the routine head pain work-up, we scheduled her for an MRI brain without contrast. A few weeks later, she returned to the office to go over the results, wherein she sheepishly asked if she could have another MRI. Puzzled, I inquired why, and it took her some time and reassurance that I wouldn't think her crazy, to tell me that: During the MRI, at three distinct points, she felt like a 'hot knife' cut through her head - she even pointed to the locations on her head and the direction of the 'knife' - the pain was described as almost unbearably intense, but only lasted a few seconds each. However, for about ten days after that, she had absolutely no headache, and felt great! (very unlike her). Slowly though, the headaches returned, and have been the same since.

This case has always intrigued me, in that her initial injury was the electric shock, and a strong magnetic field seemed to provide temporary relief.

...so maybe not every effect from MRI's are negative.
I thought you might be interested-

Theodore Jordan, DO
Columbus, OH

Editor's comment:

Dr. Jordan tells me that he saw this patient a number of years ago and that he does not have contact with her now. I wonder if there might not have been an interference field involved, and if there might have been some therapeutic possibility using neural therapy.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

Last month's newsletter was about neural therapy's ability to mobilize toxins, sometimes in unexpected and/or unwanted ways. The teaching case described a 50 year old woman who had undergone successful detoxification for chronic mercury poisoning from her own dental amalgam fillings, only to become quite toxic again after elective dental surgery. For a review see the June issue <http://www.neuraltherapybook.com/newsletters/>

This month's newsletter will be a continuation of this discussion, using questions brought forward by readers as departure points:

Hello, Dr. Kidd

I am a little confused about this possible complication of neural therapy. In your illustrative case I don't see when and how she was treated with neural therapy. She developed symptoms which you seem to ascribe to neural therapy, possibly. Did I miss something?

Barbara Powell MD

Barb,

You are quite right - The case was not really about a complication of neural therapy. Rather it was about hazards of mobilization of mercury from oral tissues.

I chose this case because it had good documentation of urinary mercury excretion on DMPS challenge, both before and after the dental procedure. The dental procedure did not involve neural therapy, but local anaesthetic was administered with (I assume) the same vasodilating effect of neural therapy.

And even if the vasodilation was not critical, the point I was trying to make was that the oral tissues are potentially important repositories of toxins. In fact the surgical procedure alone may have been enough to release the mercury. I have seen similar toxic reactions after dental or sphenopalatine ganglion neural therapy, but have not had the opportunity to document the mobilization of mercury in as clear-cut a way.

A second letter:

Robert,

Thank you for an interesting lesson. I have an interesting case that puzzles me.

Dr. A. is a 42 y/o traditional dentist, who stopped placing amalgam fillings several



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years ago, but still removes amalgam in the course of her work. She presented to my practice 3 years ago with insomnia, anxiety, restlessness and obsessive-compulsive symptoms. She has been on one medication for 6 years and wanted to stop.

After several attempts with different supplements her condition improved only slightly and I was not able to significantly decrease her medications. However, after she had 11 amalgam fillings removed things improved rapidly. She got completely well within 4-6 months, off her medications and most of the supplements.

But....the urine mercury levels continue to stay high, around 100mcg on oral DMPS provocation, in spite of treatment with DMSA and several supporting agents. A repeat IV provocation with 250 mg of DMPS produced a level of 150 mcg. After I began doing neural therapy on interference fields of the kidneys and liver (detected by autonomic response testing) her DMPS provoked urinary excretion increased to 170 mcg. We have now been in stalemate for almost 2 years. She has no symptoms. Muscle testing clearly shows mercury in her kidneys and liver, but not in any of the other usual organs, like brain, thyroid, heart, bones or ovaries.

She continues to remove amalgam in her dental office which is probably polluted, but how do you explain no changes in her testing and how come I cannot reduce the mercury level in spite of prolonged treatment?

Michael Gurevich M.D., C.Ac.

Michael,

There are two possible reasons for high mercury excretion persisting even after seemingly adequate treatment: (1) Continuing toxic exposure or (2) Impairment of physiological detoxification.

The first possibility can be tested in a number of ways: Hair analysis or unprovoked urinalysis for toxic metals are good measures of current exposure. If one or both are high, toxins from the environment are likely.

Dental offices can be highly toxic, so assessment with a mercury vapor tester should be done. The home might be checked as well. (Accidental breakage of mercury thermometers or other mercury-containing instruments can leave undetected pollution in its wake for years).

The patient should be questioned about use of Ayurvedic medicines. Some are laced with mercury or other toxic elements. I had a similar case to yours a number of years ago and when I consulted David Quig of Doctor's Data, his first question was whether my patient was using an Ayurvedic remedy. (And yes, she was!)

The second possibility - impaired physiological detoxification, has many possible causes: oxidative stress, poor hydration, poor bowel function, etc., but for mercury levels to persist that high in a seemingly healthy woman, glutathione synthesis is likely being limited by lack of amino acid precursors: methionine, cysteine and/or cystine. In chronic toxic metal toxicity, glutathione synthesis is up-regulated and the requirement for these amino acids increases markedly - a real problem for vegetarians and others with low protein diets or poor digestion. Occasionally patients will report a craving for meat - a sure sign of amino acid deficiency.

A less common cause of glutathione deficiency involves another amino acid, taurine. It may be lacking because of poor diet or intestinal dysbiosis. Taurine deficiency leads to magnesium wasting through the kidneys, which in turn leads to



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glutathione deficiency, as magnesium is an essential cofactor in glutathione synthesis.

Amino acid levels can be measured through urinalysis and glutathione levels by red blood cell analysis.

Both tests are available through Doctor's Data.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

I have often lamented the lack of peer-reviewed literature on neural therapy in the English language. However this deficiency should not prevent us from reading what has been published and so I have included in this newsletter a few abstracts from papers published in the last year. The first is actually a translation from a German language article (better an abstract than nothing!) The second is from a veterinary journal. (I know one veterinarian who is quite skilled in neural therapy and I have enjoyed learning from him.)

Research and therefore writing about neural therapy for the peer reviewed literature is not easy. The current fashion of "evidence based" practice encourages the most superficial understanding of pathophysiology, and therefore the most superficial treatments. For example, it would be easy to show that injection of a steroid suspension into a subacromial bursa will suppress an inflammatory process.

But it would be another matter to explore the factors that produced the inflammation in the first place. In my experience, subacromial bursitis is "the tip of the iceberg" of disturbed mechanics of the shoulder. And disturbed shoulder mechanics is often a reflection of disturbed mechanics elsewhere - e.g. neck, cranium, chest wall or pelvis.

Similarly, subacromial bursitis can also be caused by interference fields, often located in areas far removed from the shoulder. Sometimes neurological, anatomical, or energetic connections can be found that explain the relationships. Sometimes the relationship is a mystery - at least to me!

A certain amount of humility about what can and cannot be known is a necessary virtue in the practice of medicine. Evidence from the scientific literature can be a marvelous tool - to open our eyes to possibilities and to learn from the experience of others. But to (again) quote Speransky: "Science is analysis; diagnosis is synthesis". Diagnosis (except of acute injuries) is a process in which a complex work of art is created from the patient's history, physical examination, and other evidence. Each individual is unique in myriad ways.

This is especially true in the practice of neural therapy. The goal is to find the loci (or "interference fields") that are disturbing regulation of the body's physiological processes. "Resetting" these controls by neural therapy can often restore the patient's function to normal health. But the location of interference fields is so different and their effects on the physiology so disparate that it is impossible to assemble subjects for trials that would satisfy the rules of scientific "evidence".

One exception to these generalizations is "segmental therapy", the practice of treating the skin overlying a symptomatic tissue or the referral zone of an organ, with subcutaneous injections of procaine. Here it is possible to obtain satisfactory results with less diagnostic precision than is required to identify interference fields in (e.g.) scars or teeth.

An example of this comes from a paper published in 2006 (in Spanish) by one of our readership, Dr. Carlos Chiriboga MD of Ecuador treating a series of 64 patients with



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chronic neck pain. Here is an English translation: <http://translate.google.ca/translate?prev=hp&hl=en&js=y&u=http%3A%2F%2Fwww.terapianeur>

For those of you planning to attend the "Mid-winter Neural Therapy Retreat" (More news about this in coming months) in February 2010 near Ottawa, Canada, Dr Chiriboga will be present.

And here are the neural therapy papers, as promised above:

Development and implementation of a 'curriculum complementary and alternative medicine' at the Heidelberg Medical School]. [German] Joos S. Eicher C. Musselmann B. Kadmon M. *Forschende Komplementarmedizin* (2006). 15(5):251-60, 2008 Oct.

BACKGROUND: The 9th revision of the Medical Training Regulations for Physicians (AAppO) in October 2003 included the new compulsory interdisciplinary subject 'Rehabilitation, Physical Medicine and Complementary and Alternative Medicine (CAM)' (QB 12). The present article describes the development of a 'CAM curriculum' for undergraduate education, its implementation in the QB 12 at the Heidelberg Medical School and its evaluation. **METHODS:** According to the 6-step approach by Kern, the following aspects are presented: requirements, experiences/interests of students, learning targets, development of practical training courses and lectures, implementation, and evaluation. Experiences/interests of students were assessed by a self-developed questionnaire. Practical training courses and lectures were evaluated by school marks (1 through 6) and by a modified version of the HILVE-I. **RESULTS:** A selection of CAM methods to be included in the curriculum was made by the participating lecturers based on the criteria 'evidence' and 'prevalence in health care'. Learning targets were defined in terms of knowledge, skills and attitudes. On this basis, practical training courses/lectures comprising classical naturopathy, acupuncture/ traditional Chinese medicine and neural therapy were developed and integrated in the QB 12. Regular evaluations of the practical training courses/lectures constantly reveal good results. 69% of the 219 students questioned indicated to be interested in CAM, 27% already had gained experience with CAM themselves. **DISCUSSION:** The well-evaluated CAM courses/lectures indicate a successful development and implementation of the 'CAM curriculum' in the QB 12 at the Heidelberg Medical School. Thus, the requirements of the AAppO are met. Moreover, implementation of CAM in undergraduate education allows for the importance CAM has in every-day care of patients in Germany. 2008 S. Karger AG, Basel

Clinical efficacy of neural therapy for the treatment of atopic dermatitis in dogs. Bravo-Monsalvo A. Vazquez-Chagoyan JC. Gutierrez L. Sumano H. *Acta Veterinaria Hungarica*. 56(4):459-69, 2008 Dec.

The aim of this trial was to assess the clinical efficacy of neural therapy (NT) when treating canine atopic dermatitis. Eighteen dogs (no control group), with at least a 12-month history of having nonseasonal atopic dermatitis, were included. No medication with either glucocorticoids or cyclosporin was allowed during the trial. One set of NT was given by injecting an intravenous dose of 0.1 mg/kg of a 0.7% procaine solution, followed by 10 to 25 intradermal injections of the same solution in a volume of 0.1-0.3 mL per site. Dogs were given 6-13 sets of NT during the therapy. The dermatological condition of each patient was evaluated before and after the treatment using two scales: the pruritus visual analogue scale (PVAS) and the canine atopic dermatitis extent and severity index (CADESI). The reduction of pruritus was statistically significant using a Wilcoxon matched-pairs signed-ranks test ($P < 0.001$). No adverse side effects were observed. NT seems to be an effective alternative to control signs related to canine atopic dermatitis.



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Patient satisfaction of primary care for musculoskeletal diseases: a comparison between Neural Therapy and conventional medicine. Mermod J. Fischer L. Staub L. Busato A. BMC Complementary & Alternative Medicine. 8:33, 2008.

BACKGROUND: The main objective of this study was to assess and compare patient satisfaction with Neural Therapy (NT) and conventional medicine (COM) in primary care for musculoskeletal diseases. **METHODS:** A cross-sectional study in primary care for musculoskeletal disorders covering 77 conventional primary care providers and 18 physicians certified in NT with 241 and 164 patients respectively. Patients and physicians documented consultations and patients completed questionnaires at a one-month follow-up. Physicians documented duration and severity of symptoms, diagnosis, and procedures. The main outcomes in the evaluation of patients were: fulfillment of expectations, perceived treatment effects, and patient satisfaction. **RESULTS:** The most frequent diagnoses belonged to the group of dorsopathies (39% in COM, 46% in NT). We found significant differences between NT and COM with regard to patient evaluations. NT patients documented better fulfillment of treatment expectations and higher overall treatment satisfaction. More patients in NT reported positive side effects and less frequent negative effects than patients in COM. Also, significant differences between NT and COM patients were seen in the quality of the patient-physician interaction (relation and communication, medical care, information and support, continuity and cooperation, facilities availability, and accessibility), where NT patients showed higher satisfaction. Differences were also found with regard to the physicians' management of disease, with fewer work incapacity attestations issued and longer consultation times in NT. **CONCLUSION:** Our findings show a significantly higher treatment and care-related patient satisfaction with primary care for musculoskeletal diseases provided by physicians practising Neural Therapy.

Letters:

To the editor:

I had an amazing case this week that I thought you would be interested in.

A patient was sent to me from a general practitioner in Nov 2008. She had tried dealing with this on a nutritional medicine approach to no avail.

62 year old man with severe rheumatoid arthritis, psoriasis and heart palpitations. In his own words he could barely walk from the bedroom to the bathroom. His oral health was really poor.

We removed some teeth, thoroughly curetting all sockets, irrigated with procaine and did extensive perio in our hygiene department. I removed some old amalgams and decay and made him new upper and lower dentures. He had no other medical treatment during this time treatment.

Saw him yesterday. No signs of symptoms of arthritis, psoriasis or heart palpitations. In fact he is heading over to Perth in Western Australia, over 3000 miles away, with his bike and intends to cycle across Australia!!!

Needless to say he was pleased.

Ron Ehrlich B.D.S.
Sydney, Australia



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To the editor:

Thanks so much for you valuable tips.

I had a patient come to the office this week with a terrible pain in his neck radiating around his jaw on both sides and up to his temple on one side. He was on Oxycontin from the ER. He had lost 7 pounds, and had no appetite. His brain CT was normal, but some spondylolisthesis showed in his neck Xray.

I looked it up in the text book you recommended, and proceeded to do only four injections on him, two in his neck area over the vertebrae and one in either angle of his jaw

That night he went home, was able to eat, no longer needed pain meds, and now is not sure he needs to go for temple artery biopsy for arteritis. It was amazing and what was even better is that I had two medical students with me, who also saw for themselves how neural therapy works.

Without your guidance this would not have been possible. This is a wonderful tool to have in our 'doctor bags.' I guess he just had a severe sympathetic response from his neck degenerative arthritis. He returned the next day for another injection, but was still much better.

Jennifer Armstrong MD
Ottawa, Ontario, Canada.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

Tourette's Syndrome is a relatively common childhood neurological condition. Its signs are so distinctive and so peculiar, that even lay people can diagnose it.

This is what happened about a year ago, when a worried mother brought her nine year old son to my office for consultation. He was a pleasant cooperative lad, a bit pale with dark circles around his eyes, but within a few minutes he was grimacing and his face was twitching in a manner typical of Tourette's. His mother reported that his tics had begun gradually four years previously and were getting worse. In addition he was at times "barking" in a strange way. She had done some reading and already had made the correct diagnosis.

Interestingly, the boy had also developed asthma over the same time period (4 or 5 years). His mother said that he had trouble breathing at birth and had been susceptible to lung infections all through his childhood. He also had infant colic and recurring ear infections as a young child.

I had been reading not long before about the association between many neurological diseases (e.g. polyneuropathy and cerebellar ataxia) and gluten sensitivity. The boy's family history revealed many relatives with cancers (stomach, pancreas, blood, thyroid, breast and lung), depression and alcoholism - all markers of gluten sensitivity.

Physical examination was unremarkable except from the pallor and above-mentioned darkness around the eyes ("allergic shiners"). Autonomic response showed a response to milk powder, indicating a sensitivity to dairy products.

An enterolab stool analysis was performed which was strongly positive for antigliadin IgA and moderately positive for antitissue transglutaminase IgA and anti-casein IgA. Genetic testing showed the presence of one celiac and one gluten sensitive gene.

Treatment was strict avoidance of dietary gluten and dairy products, supplemental vitamin D, B12, magnesium, other intracellular minerals and a probiotic. Within a few weeks, the Tourette's signs decreased and within a few months, they were almost gone. A surprise extra benefit was that his asthma also disappeared.

However a sudden relapse came four months later. The asthma was the first to reappear; then the tics. The onset of the tics seemed to coincide with the use of an Atrovent (ipratropium) inhaler. This time, an interference field was detected in the left lung. This was treated with neural therapy. The response was immediate cessation of both the tics and the asthma.

This lasted about a month until he caught "the flu" and again had a relapse of the Tourette's and the asthma. Once more neural therapy of the left lung arrested both the asthma and the Tourette's - this time for three months.



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For neural therapy and advanced healing



This most recent relapse coincided with treatment with nitrous oxide gas for a dental procedure. A left lung interference field was again found and treated by neural therapy.

This case is interesting for two reasons. First: the response to dietary gluten and dairy elimination, and second: the response to treatment of the interference field in the lung.

As mentioned in a previous newsletter (Vol. 2, No. 9, September 2007 of <http://www.neuraltherapybook.com/newsletters/>), gluten acts as a neurotoxin in some gluten-sensitive people. In recent years research has been accumulating supporting the hypothesis that Tourette's is an autoimmune disease. A very recent paper from Russia reports the discovery of antibodies to caudate nucleus proteins and a more than 6 month remission in symptoms in 7 patients after transfusion with immunoglobulins.

Epidemiological studies show that Tourette's is more common in celiacs, but there is little other evidence in the peer-reviewed literature on the relationship between gluten and/or dairy sensitivity and Tourette's syndrome. However in the popular literature there are numerous reports of successful treatment of Tourette's syndrome by dietary manipulation.

The relationship between the interference field in the lung, asthma and the Tourette's symptoms is much harder to explain. However a fundamental observation in the practice of neural therapy is that interference fields can be found anywhere in the body and can produce symptoms anywhere in the body. The brain is no exception.

I have never identified an interference field related to Tourette's syndrome before, but have occasionally seen interference fields triggering epilepsy. Teeth are likely culprits. I would suggest that all medical conditions with a dynamic component should be searched for

interference fields. And this applies to neurological diseases as well.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

Physicians are not often asked to see patients for toothache. And most physicians wouldn't know what to do anyway. However we sometimes see patients with toothache, either before or after they have consulted a dentist. The vast majority of cases the dentist diagnoses and treats successfully, but some seem to defy most dentists' skills.

Sometimes diagnosis is difficult because an occult infection or dental fracture is too subtle to be detected in the usual ways. X-rays and the usual physical examination show only so much. On other occasions, pain results when the nervous system plays a "neurological trick", e.g. produces pain from a nearby (or distant) interference field.

When diagnosis is difficult and the patient is in a great deal of pain, the dentist is sometimes pressured to perform an endodontic procedure or a "root canal". When this fails, the patient sometimes pleads to have the tooth extracted. The situation becomes even more desperate when pain persists after the tooth is gone.

On more than one occasion, I have seen patients with three adjacent tooth spaces, each tooth treated endodontically and then extracted, in a futile effort to chase down the source of dental pain.

Neural therapists learn early that teeth themselves can be interference fields. If they are uncomplicated by infection or electro-galvanism, neural therapy may be all that is needed to permanently abolish the pain. The classical method of diagnosing the interference field is by test injections of dilute procaine into the mucosa overlying the suspect teeth.

Alternatively, autonomic response testing can identify the dental interference field, and with great precision. Usually the interference field is on just one aspect (lingual or buccal) of the tooth and therefore needs treatment on only that side.

An additional advantage of autonomic response testing is that it can indicate a complicated dental interference field, i.e. one that harbours an infection. Procaine is unlikely by itself to abolish the interference field in these cases. Here one must add a homeopathic or isopathic to the procaine solution. Dental infections almost always subside with this treatment - one or two treatments a week for up to three weeks. (Isopathics are homeopathic-like remedies (Sanum remedies) manufactured by Sanum-Kehlback GmbH & Co.) Autonomic response testing will indicate the appropriate remedy for each type of infection.

In the more difficult to diagnose cases of dental pain, the source of the pain is sometimes not in the teeth themselves but rather in interference fields in the adjacent autonomic ganglia - sphenopalatine for upper teeth, submandibular for lower ones. These should be routinely checked in all cases of dental pain of obscure origin. Treatment of these ganglia solves many puzzles of dental as well as facial pain.



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For neural therapy and advanced healing



Other contributors to neurological overload of the ganglia, such as occult facial sinus infections, tonsillar interference fields and somatic dysfunction in the cranium and neck need to be identified and treated or the autonomic ganglia interference fields will recur.

In recent years I have found that the Tenscam device treats dental interference fields as effectively or even more effectively than procaine injections. (No needles!). This holds true even when using homeopathics or isopathics. The remedy vial is simply held over the tooth and the Tenscam "beam" directed through it to the infected tooth.

Next month: more about obscure dental pain.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

For experienced neural therapists, please look at the notice at the bottom of this newsletter:

Dear Colleagues:

Last month I suggested some methods for diagnosing toothache, when the dentist has found no obvious cause for it. These included interference fields in the tooth itself, or in nearby autonomic ganglia (usually sphenopalatine ganglia for upper teeth and submandibular for the lower teeth). And I also suggested methods of treating them. (See <http://www.neuraltherapybook.com/newsletters/> Vol. 4, No 10).

There are yet other causes of dental pain that the dentist is unlikely to detect. These occur when pain is referred from trigger points in certain muscles. The tricky part about trigger points is that they may refer pain to locations quite distant from the trigger point, just as pain refers from visceral organs. But in the case of dental pain, the muscle trigger points are all located in the head and neck.

According to Simons and Travell's classic textbook "Myofascial Pain and Dysfunction: The Trigger Point Manual" there are three muscles likely to refer pain to teeth:

1. Temporalis - upper teeth
2. Masseter - upper and lower premolars and molars
3. Anterior digastric - lower incisors

One tip-off that pain is being referred from a muscle trigger point is that pain is usually felt in other places than just the tooth. For example, temporalis trigger points usually also provoke pain in the temple or in the low forehead.

The diagnosis is confirmed by palpating the characteristically tender nodules in the muscle and then by a therapeutic trial - usually involving local anesthetic injections.

No physician practicing clinical medicine should be without the *Trigger Point Manual* (2 volumes). It is truly one of the great medical books of all time. The text is rich with clinical pearls; the illustrations are outstanding and best of all, it is organized in such a way that looking up trigger points and their referral patterns is easy, even for the busiest practitioner.

Now, where does neural therapy fit into all this? The answer is - in a number of ways. Janet Travell was familiar with the same body of science that the early neural therapists were. She correctly deduced that dilute procaine would treat trigger points and the associated pain. But she also discovered that a longer lasting effect could be obtained by (in addition) stretching the muscles. And she realized that "perpetuating factors" such as mechanical disturbances, malnutrition and psychosomatic factors had to be addressed to prevent recurrence.



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The modern neural therapist has the same and additional options. Trigger points can be detected not only by palpation but also by autonomic response testing, i.e. touching an active trigger point makes an indicator muscle go weak. When deciding on treatment, segmental therapy, injections of "quaddles" of dilute procaine into the skin overlying the affected muscle. (see page --- of <http://www.neuraltherapybook.com>.) can be as effective as trigger point injections. Stretching of the muscles is not required.

One might also search for interference fields that explain the genesis of the tight muscles. Somatic dysfunction of related vertebrae can be treated either by manipulation or by neural therapy (quaddles of dilute procaine into the skin over the vertebra).

Tight muscles in the head and neck may be part of a whole-body pattern, in which whole-body assessment and treatment is necessary. Cranial somatic dysfunction can also cause tight muscles. For those who are not trained in cranial osteopathy (or craniosacral therapy), a history of head trauma, however remote, should be reason enough for referral for cranial assessment.

Psychological factors may be important in tight muscles, especially masseters. The patient who is enduring anger and frustration, perhaps "through clenched teeth" is prone to toothache not only through dental malocclusion, but also from referral from trigger points.

A letter from a reader:

The tooth issue is of course a major health concern, and although you may manage dental pain with neural and homeopathic remedies, the offending tooth, once infected to the point that the blood flow through the apex is blocked, will invariably have to be removed as part of clearing the interference field.

Many, in fact, most "biological dentists" are still trying to do a better root canal therapy, when the fact is that the tooth is dead and gangrenous and cannot be revived. The lack of a biological mechanism for re-establishing blood flow and nerve innervation to the interior tooth pulp tissue, makes it illogical to mechanically rebuild the tooth. Once the pathological degeneration cascade has reached a certain point, there is no reversal possible. There are exceptional cases though for maintaining function and position of the tooth by doing root canal, as long as we accept it only as a temporary measure for which there may be a biological price.

*Hans Schwartz DDS
Markham, Ontario, Canada.*

Editor's comment:

I agree with Dr. Schwartz. Once the tooth has become gangrenous, neural therapy is a temporary measure. However it can be "life-saving" for that tooth that is close to death and for which the dentist is sometimes recommending root canal treatment.

Neural therapy's role is to optimize the body's defense mechanisms. However in the case of the dead tooth these defenses must be maintained throughout life. If the body's defenses falter, the root canal may come back to haunt the patient, often in subtle ways.



This year we have as a special guest, Dr Carlos Chiriboga, an orthopaedic surgeon from Ecuador. As many of you know, "two solitudes" exist in neural therapy - the world of Spanish and German speakers - and the rest of us. Fortunately, Dr Chiriboga speaks English and we look forward to this opportunity to learn more about neural therapy as practiced in the Spanish-speaking countries.

Lynne August will be returning for this meeting and will speak on "Practical tips to be gleaned from minor changes in blood chemistry". She is also again offering free "Health Equations" <http://www.healthequations.com/> blood test evaluations to course participants. After you have registered, contact my (Dr. Kidd's) office, for information on how to go about this.

anced techniques in autonomic response testing; Bernadette Kohn from Chicago y; Michael Gurevich, from Long Island NY will be sharing experiences from his importance of autonomic ganglia in neural therapy.

Volume 5, No. 1, Jan. 2010

NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of Neural Therapy: Applied Neurophysiology and Other Topics

Dear Colleagues:

This month I would like to discuss a commonly overlooked reason why our patients do not respond to neural therapy as well as they should. I am speaking here of course about those in whom an interference has been identified and treated, sometimes with a good initial response, but where the response to repeat treatments is disappointing.

When this happens, we think of underlying conditions affecting cell membrane stability. Environmental neurotoxins and nutritional deficiencies come first to mind, but a simple, easily remedied condition is probably almost as common - namely, dehydration.

Chronic, low-grade dehydration is easily missed, perhaps because patients do not feel dehydrated. What they are more likely to experience is cold hands and feet, dry skin, weakness, postural hypotension and fatigue. They may also have stomach problems and/or constipation. These symptoms are often mild and seldom volunteered by the patient.

Dehydration can be detected on physical examination. Low blood pressure may be present. The hands and feet are often cool and a pinch of skin on the dorsum of the hand should immediately flatten when released. If the skin pinch does not



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For neural therapy and advanced healing



disappear within a second or two, the subcutaneous tissues are probably drier than they should be.

Some people simply do not drink enough, especially in warm, windy weather or after vigorous exercise. Or they may drink the wrong things. In my experience, coffee drinkers are frequently dehydrated. Drinking coffee and other caffeinated drinks result in a net loss of fluid because of the diuretic effect of caffeine. Alcohol does the same thing and too much of it may be part of the explanation for "hangovers". Pharmacologic diuretics may also cause dehydration, if adequate liquids are not consumed to compensate for them.

Hydration is not just a matter of water. Some health-conscious patients aim to drink eight glasses of water a day. They are often the ones with plastic water bottles in hand, as if preparing to walk the Sahara! Paradoxically, they may not be able to "hold" their water; the water just passes through them.

The reason they cannot "hold" their water (I am not speaking about bladder capacity!) is that their extracellular space does not contain enough minerals to maintain isotonicity. The body makes the tonicity of the extracellular space a priority over volume, so if the extracellular minerals are lacking, the volume decreases. This leads to reduced tissue circulation and to the symptoms mentioned above.

Minor changes in blood chemistry (i.e. changes within the reference range) can be markers of dehydration. Low or high serum sodium, or high BUN should be watched for. A low chloride (a neglected element in clinical medicine!) is a particularly good sign. Health Equations <http://www.healthequations.com/> provides a "hydration index" quantitating these and other serum components.

The minerals most commonly lacking are sodium and chloride. Often the most health conscious patients are salt deficient, as they have been lead to believe that salt is bad for them. Because excess dietary salt can exacerbate hypertension in some people, the prevailing belief that everyone should restrict dietary salt has taken hold. As with so many other medical fashions, a good idea carried too far has unintended consequences.

Encouraging increased consumption of salt in addition to water can be very helpful in many of these cases. However electrolyte solutions (containing other minerals such as phosphorus, bicarbonate, sulfates, potassium, and magnesium) work even better. Some commercially available products are Health Equations' <http://www.healthequations.com/> Lyte solutions and Body Bio's <http://www.bodybio.com/> E-Lyte solutions.

If dehydrated patients are hypertensive, I always make sure that they are taking adequate magnesium before recommending increased salt consumption. (I suspect that sodium-sensitivity in hypertensives is an indication of magnesium deficiency.) They should also check their blood pressure regularly, holding back on salt if blood pressure increases.

A good way of remembering the importance of hydration when practicing neural therapy is to remember that interference fields are associated with disturbance of the electrical properties of cell membranes. Electrolytes both within and without the cell, separated by the hydrophobic cell membrane, maintain the electrical charge of the cell membrane. Some failures of neural therapy occur because the electrolyte solutions are simply inadequate for maintaining the electrical charge.

Since procaine's role in neural therapy is to restore the cell membrane's resting potential, maintaining adequate hydration and extracellular electrolytes can be looked



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upon as adjuncts to neural therapy.

Volume 5, No. 2, Feb. 2010

NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of Neural Therapy: Applied Neurophysiology and Other Topics

Dear Colleagues:

Some of our readership have recently returned home from attending a "Mid-winter neural therapy retreat" at a country inn in the hills just north of Ottawa in Canada. The purpose of these "retreats", held every two or three years, is to allow experienced neural therapists an opportunity to meet and learn from each other in a relaxed and informal manner. This year our special guest was Dr. Carlos Chiriboga, an orthopaedic surgeon and experienced neural therapist from Guayaquil, Ecuador.

As some of you are aware, there is little communication between those practicing neural therapy in the Spanish speaking countries and those in the English speaking world. However I was aware that neural therapy was practiced widely in South America and that large congresses are held from time to time. I had also heard (from a German correspondent) that South America is recognized by many as leading the world in neural therapy at this time. So South America is clearly a place to watch!

One of the pleasures of writing these newsletters is to meet (over the internet) physicians from all over the world who share a passion for finding new ways to help their patients. This is how I came to meet Dr. Chiriboga. Dr Chiriboga spoke at the meeting and then spent two days with me in my own office. His knowledge and skills confirmed what my correspondent had told me. We have much to learn from the South Americans!

A little example: When searching for interference fields, Dr Chiriboga uses a little specially-made mirror which he passes over the body while monitoring the patient's radial pulse. The mirror picks up subliminal energy emitted from the interference field and reflects it back, stimulating an autonomic response. This change in pulse is called VAS (or vascular autonomic response) and provides the same information as does change in strength of an indicator muscle. A variety of mirrors can be used to filter for different conditions affecting the interference field, e.g. allergy, metabolic problems, etc.

Dr Chiriboga does use muscle strength testing for certain purposes, but rather than the shoulder flexor muscles (commonly used as indicators in autonomic response testing and applied kinesiology), he uses the Omura bi-digital O-ring test.

Dr Chiriboga also uses a specially-made laser for both diagnosis and treatment of interference fields and other problems. This "soft" laser emits a variety of ELF (extra low frequency) signals to match the patient's requirements.

These tools were developed by Dr. Jorge Carvajal, a highly influential Columbian physician, teacher and author of numerous medical books. Dr Carvajal teaches a medical system called "Sintergetica medicine", a synthesis of Chinese, Tibetan, Ayurvedic, South American shamanistic and Western medicine. As a young man he received his medical training in Columbia, spent time with an Amazon jungle shaman,



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For neural therapy and advanced healing



and went on to study in Belgium and France where he was heavily influenced by the physiologist Pischinger and the french physician Paul Nogier (the originator of auricular medicine).

Physicians from all over South America go to Columbia to be trained by him and he also travels extensively to speak and teach.

However, Dr Carvajal was not the one to introduce neural therapy to South America. The pioneers were Dr Julio Cesar Payan and Dr Germán Duque, who both studied under the Huneke brothers in Germany. They founded the Los Robles Clinic in Columbia, which continues to this day as a teaching center for Sintergetica medicine and neural therapy.

I was surprised to see variations of autonomic response testing to be practiced at such a high level and asked Dr Chiriboga how this had come to be introduced to South American neural therapy. His understanding is that Dr Duque was influenced by the work of George Goodheart DC (the originator of applied kinesiology). However he eventually learned and taught the Omura O-ring test as his preferred method for detecting autonomic response.

There are many thousands of physicians in South America practicing neural therapy. I am honoured to have some of them subscribe to this newsletter and sometimes even to receive comments from them.

A neural therapy "congress" is held in Latin America every two years and this year it will be in Guayaquil, Ecuador. The dates are March 11-14 and simultaneous translation into English will be available. <http://www.neuraltherapybiennial.com/home.html>.

Volume 5, No. 3, March 2010

NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of Neural Therapy: Applied Neurophysiology and Other Topics

Dear Colleagues:

This month I would like to continue my report on neural therapy in Latin America. I am using the term "Latin America" this time because I want to include Puerto Rico, which of course is not (geographically) a part of South America. I will explain what I mean by all this below, but first a couple of corrections of errors in my last newsletter.

The first correction is that the clinic "Los Robles" is the centre of neural therapy teaching in Columbia and is located in Popayan. (Some of you will have seen that name on a widely circulated dental - acupuncture meridian chart.) Sintergetic medicine is taught in Medellin and Bogota, Columbia.

The second correction is the name of the city hosting the international conference on neural therapy this March. It is not Guayaquil, but Quito, Ecuador's capitol. Hopefully this has not spoiled anybody's plans to attend, because by the time you read this, the meeting will be over.



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Now, back to the subject of Puerto Rico: At our recent "Neural therapy mid-winter retreat" our special guest was Dr. Carlos Chiriboga of Guayaquil Ecuador. (He is a leader in neural therapy in South America and was mentioned in last month's newsletter). Dr. Chiriboga was a little insecure about his spoken English so he asked that his friend Dr. Osvaldo Font of Puerto Rico be invited to help him. I was only too happy to do that, as I had heard that Dr. Font's presentation on "electroneuromedular medicine" at a big conference in Baden-Baden in 2008 had caused quite a stir.

Dr Font graciously agreed to come, to assist Dr. Chiriboga and also to give a "short presentation" on his own work. He did just that at the conference, and he did not disappoint!

Dr. Font's approach bears similarities to neural therapy, and might even be considered a variation of neural therapy. However procaine is not a primary part of treatment, nor are interference fields searched for in the usual ways. Where it resembles neural therapy is its effect of altering abnormal autonomic nervous system tone, particularly in the region of the spine.

Electroneuromedular medicine targets the spine, more specifically the dura mater. In cases of chronic pain or spinal cord injury, a long acupuncture needle is inserted into the spine until the tip touches the dura mater. The patient feels a sharp pain, often in an extremity, and the operator feels a powerful shock in his or her fingers through the needle from the dura itself. Dr. Font explained that dura mater carries a voltage of approximately 115 volts at a 60 Herz frequency, i.e. much like that in North American house wiring.

When contact is made, Dr. Font attaches a hand-held pulse generator to the needle that "revs up" the frequency, i.e. increases it to a couple of hundred Herz. The patient feels pain in various parts of the body corresponding to the spinal tracts being stimulated.

The effect can be dramatic. In one of his films, a young woman presented with complete paraplegia resulting from a spinal tap seven years previously. Electroneuromedular treatment resulted in her being able to walk away from her wheelchair and progress to a complete cure.

I found this case particularly interesting, as it seems unlikely that direct trauma from a spinal tap could damage the spinal cord to such an extent. Clearly some sort of reactive vasospasm must have been the mechanism of injury. If this was true, bringing back normal sympathetic tone might have been enough to restore circulation and "re-awaken" sleeping nerve cells.

I have seen significant improvement in brain function after traumatic brain injury and cerebro-vascular accidents with neural therapy (e.g. the "crown of thorns" procedure) and by cranial osteopathy. Japanese scalp acupuncture has a reputation for efficacy in this area as well. The rationale is that around every brain injury is a "penumbra" of brain tissue that is still alive and that can be re-awakened by improving cerebral circulation. Whether this is the mechanism or not, Dr. Font's electroneuromedular therapy stands in a class of its own in treatment of spinal injury.

Dr. Font told me that an inspiration for his work was Robert Becker, author of the classic book "Body Electric". Among Becker's many contributions to our knowledge of body electricity was the discovery that fracture non-union or delayed union could be cured by applying a specific electrical current across the fracture site. It strikes me that Dr. Font's treatment of spinal cord injury may operate in a similar way.



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Of course this is speculation on my part and I would be interested in Dr. Font's or others' opinion of this interpretation. You can see film-clips related to his work using the search words "Osvaldo Font" on <http://www.youtube.com/>. Dr. Font is also hosting an international meeting "Primer Congreso de Medicina Integral y Anti-Envejecimiento en el Caribe" in Puerto Rico from September 1st to 5th, 2010. English translation will be available at this meeting.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues,

This neural therapy newsletter marks the beginning of our sixth year. I want to use this opportunity to thank you - my readers, for all the interesting feedback and encouraging letters. They come from all over the world, are often informative, and are all very much appreciated. For those of you who have signed on only recently, past newsletters can be found in the archive at <http://www.neuraltherapybook.com/newsletters>

"Solar plexus" is a word I first heard as a youngster, growing up in rural Canada listening to the blow-by-blow descriptions of the Friday night boxing on radio. When a boxer landed a hard blow to the "solar plexus" we knew that it mattered. It might be a knockout!

This term isn't used much these days. In the not-so distant past it was used to describe what we now call the "coeliac plexus". And (according to the Wikipedia) it is sometimes used as a translation of the Sanskrit word manipura referring to the chakra corresponding to the umbilicus. This strikes me odd, as both the region "solar plexus" and the anatomical term "coeliac plexus" are located in the epigastrium, well above the umbilicus. Perhaps a reader could clarify this point.

In any case, the coeliac plexus is important in the practice of neural therapy. It is not an uncommon interference field and powerful beneficial effects can be obtained when detected and treated.

The coeliac plexus is the largest plexus in the body; it is a poorly defined network of nerve fibers and ganglia situated anterior to the abdominal aorta at about the level of the first lumbar vertebra. Anteriorly, its center can be found by palpating the abdominal aorta at a level corresponding to the midpoint between the tip of the xiphisternum and the umbilicus.

The coeliac plexus has connections with the vagus nerve, the thoracic and lumbar sympathetic ganglia, the stomach, pancreas, liver and small and large intestines. It serves as a nerve connection center distributing afferent and efferent information throughout the enteric, sympathetic and parasympathetic nervous systems in the abdomen. It is also involved in decision-making; afferent fibers synapse with efferent fibers in this region and can modify efferent output, i.e. complex activity can occur without the involvement of the brain or spinal cord.

The coeliac plexus should be considered a possible interference field in any condition of chronic or recurrent gastrointestinal dysfunction. This is especially true if interference fields are found in more than one of the abdominal organs. The coeliac plexus lies behind the stomach in an anatomical sense, and coeliac plexus interference fields "lie behind" the stomach and other abdominal viscera in a functional sense.

A typical story would be recurrent stomach and bowel problems for many years following amoebic dysentery or some other particularly severe gastrointestinal infection. Interference fields are found in the stomach, liver and possibly other organs, but no lasting relief is



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obtained until the coeliac plexus interference field is identified and treated. Occasionally, coeliac plexus interference fields may be found associated with lower thoracic sympathetic ganglia interference fields.

Coeliac plexus injections, (despite appearances) are simple and safe using an anterior approach. Even in quite obese patients the abdominal aorta can be palpated if enough gentle pressure is applied. Two fingers cradle the aorta and the needle is inserted between the fingers until the firm resistance of the aorta is felt. Obviously abdominal viscera are penetrated, but using a fine needle, no harm is done. Details may be found in my book on page 187 available at <http://www.rfkidd.com/booksite/>.

The coeliac plexus should be looked at as a "breaker switch" for the autonomic innervation of the abdominal viscera. Just as an electrical breaker switch "flips" and shuts off current flow when overloaded, so also do autonomic ganglia go into an "alarm state" when neurological traffic is too heavy or too intense.

A short case history: A 42 year old woman presented with stomach and bowel upsets, fatigue and depression since contracting an undiagnosed tropical disease in Indonesia 12 years before. During the illness she had experienced some jaundice. No specific infectious agent had been identified.

On the first visit, an interference field was detected by autonomic response testing. Neural therapy "quaddles" were placed over the stomach segments and a mild temporary improvement was experienced for a few days.

Repeat examinations and treatments of liver and large bowel interference fields also produced only temporary improvements. Only when a coeliac plexus interference field was identified and treated with a coeliac plexus block was a truly satisfactory and lasting response achieved. Not only did the gastrointestinal symptoms disappear, but the patient's energy and sense of well being improved also.

Next introductory neural therapy course on November 12th and 13th, 2010 in Ottawa, Ontario, Canada. <http://www.neuraltherapybook.com/NTcourses.php>.

Three-day introductory neural therapy course in Sydney, Australia March 9-11, 2011.
For more information contact George Stylian DO: 02 9524 4620, 0425 237 995
or gstylian01@optusnet.com.au;
FAX: 02 9525 9998



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

For anyone practicing neural therapy, the subject of mercury toxicity comes to the fore sooner or later. Mercury toxicity is a common cause of poor response to treatment; it may block regulation; it may underlie "too many" interference fields, and it sometimes is a complication when neural therapy is directed at interference fields with **sequestered mercury**, (e.g. the oral cavity and face). In this situation, the patient is actually made sick by the neural therapy. Mercury toxicity is a large and important topic discussed (in a limited way) in chapter 9 of my book on neural therapy: <http://www.neuraltherapybook.com/>

It is also a difficult subject. Unlike acute mercury toxicity, chronic mercury toxicity is subtle and cannot be detected with the usual laboratory methods. **Most physicians suspecting this condition have come to rely on chelating agents such as DMPS and DMSA** to uncover the toxicity. A test dose is administered orally or intravenously; the chelating agent circulates through the body binding mercury and other divalent cations and is then excreted in the urine. The amount excreted is said to represent the **"body burden"** of that particular toxin.

However, clinicians quickly observe that **the correlation between the amount excreted and the health of the patient is poor.** Relatively healthy patients sometimes excrete large amounts; tired and sick patients sometimes excrete little, even though the history, examination and other lab parameters strongly suggest mercury toxicity. The tendency then is to blame "impaired detoxification".

A new commercial lab has just appeared on the scene that shows promise in resolving some of these quandaries. **Quicksilver Scientific** <http://www.quicksilverscientific.com/>, founded and operated by Christopher Shade, PhD offers two unique services:

1. Quantitative mercury analysis at extremely low serum concentrations.
2. **Mercury "speciation"**, i.e. quantitative analysis of both organic and inorganic mercury in blood, hair and urine. (The commonest source of organic mercury is dietary fish; the commonest source of inorganic mercury is dental amalgam).

Dr Shade demonstrates (using published literature almost 20 years old) that **serum mercury levels are actually a good measure of the body's burden** in the chronic state, i.e. the serum concentration is in equilibrium with that in the tissues. The problem for clinicians is that most labs do not offer measurements at a low enough range for this knowledge to be applied. Quicksilver lab does.

The second breakthrough that Quicksilver Scientific seems to provide is an assessment of the body's ability to excrete mercury through the liver and kidney pathways. This is done



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For neural therapy and advanced healing



by firstly "speciating" the mercury i.e. measuring independently the methyl and inorganic forms of mercury in the serum, and secondly measuring mercury concentrations in hair and urine. Since the mercury in hair is primarily in the methyl form and the mercury in urine is primarily inorganic, calculations can be made to determine how well (or poorly) each excretory pathway is functioning. It is assumed that hair levels reflect excretion of methyl mercury through the liver-bowel route.

This has some obvious therapeutic implications, and especially for those practicing neural therapy. Not only do rational, individually-tailored detoxification strategies need to be designed, but **interference fields need to be identified and treated, especially in the kidneys, liver, gut and associated autonomic ganglia.**

I have been starting to use the Quicksilver lab and have so far found the results useful. Sometimes even knowing that a patient's excretory pathways are working well is valuable knowledge!

However as valuable as this information may be, I see **one potential pitfall** in Quicksilver lab's basic assumptions. Serum mercury is said to "reflect the body burden" because in the chronic condition blood mercury levels are in equilibrium with those in the tissues. This assumes equal availability of mercury for diffusion from all tissues, but those experienced in neural therapy know this is not the case. **Mercury is often sequestered in tissues with reduced blood flow**, typically those with chronic inflammation or interference fields of various types including somatic dysfunction. This is evidenced by neural therapy (or "deep" osteopathic manipulation of longstanding major somatic dysfunction), mobilizing mercury that would otherwise not be reflected in the steady state equilibrium of tissues with serum.

The question of mercury toxicity vs mercury sensitivity is another remaining dilemma (and too large a subject to be discussed here) but despite these limitations, **I feel that Quicksilver lab's new services are promising additions to the clinician's armamentarium.** I look forward to seeing how this plays out in not only my own practice but also those of other clinician.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

When conveying ideas about neural therapy (or any other area of medicine), case histories can be very helpful. Short and concise histories work best. Irrelevant material is trimmed away to bring out certain teaching points.

As useful as they may be in teaching, straightforward cases are the exception in real life. Most of my patients present with a variety of complaints, complicated histories, and "background issues" i.e. underlying nutritional, toxic, immune, emotional, social or existential problems. Simple, one-answer solutions are the exception.

Even when a simple solution seems within reach, the general condition of the patient will often decide otherwise. Response to treatment may be disappointing or temporary. Or other health problems will crop up.

This month I want to present a case which illustrates how complex decision-making can be in neural therapy. The experienced neural therapist will recognize this scenario immediately; the beginner will hopefully realize that complexity should not come as a surprise.

(My comments - in red.) In August of last year, an alert 87 year old lady accompanied by her daughter, presented with severe right-sided neck pain beginning a few weeks after a coronary artery stent procedure, 1♦ years before. She was an insulin dependent diabetic and was taking oxycodone-acetaminophen for pain, glyburide, nifedipine, fosinopril, pantoprazole and citalopram.

The neck pain was unaffected by posture or movement and examination revealed no significant somatic dysfunction in the neck or elsewhere. The history was highly suggestive of interference fields in either the heart or the catheterization scar at the right femoral artery, but autonomic response testing (ART) instead revealed (to my surprise) an interference field in the right third lumbar sympathetic ganglion. Neural therapy (using the Tenscam device) resulted in significant relief from the pain for three days.

On the next visit, autonomic response testing revealed no interference field in the lumbar region, but instead one in a surgical scar over the right ankle. Surgery had been performed for a fracture four years earlier (probably a contributor to the lumbar sympathetic ganglion interference field at the previous visit). This time neural therapy resulted in 10 days relief and considerable improvement in energy and well-being.

Unfortunately, from this point, the patient no longer responded to neural therapy even though interference fields were found in the right stellate ganglion, right femoral artery puncture site, right acromio-clavicular joint and other locations. Her pain was increasing and she was becoming increasingly depressed and discouraged. "Fading response" is often an indicator of cell membrane instability.

The patient's general health was therefore evaluated more carefully. Signs of dehydration, (cool hands and feet, lack of skin turgor), light-headedness, alterations



Dr. Robert F Kidd, MD newsletter archive
For neural therapy and advanced healing



of serum electrolytes and BUN were detected. In December the patient was prescribed oral electrolytes and other nutritional support.

After this treatment, neural therapy of her lumbar sympathetic ganglion provided a few days relief and her analgesic requirements dropped by 50%. This response was encouraging, but with repeat neural therapy treatments, progress again stalled.

On the next visit, (in February) autonomic response testing indicated a need for vitamin B12. (The patient had reported that vitamin B12 injections had helped her energy in the past.) In February a course of daily vitamin B12 injections was undertaken. Again - a good response to neural therapy with decreased pain and increased energy and sense of well-being.

However B12 did not prove to be the answer. Responses to neural therapy again faded even though the patient was feeling overall better.

In April, the question of hydration was revisited and the blood chemistry was repeated. Almost no improvement was detected clinically or in the serum markers of hydration. Further questioning revealed that in the seniors' home where she lived, a "low salt policy" was in effect. No salt was added in cooking and the use of salt at the table was discouraged.

This time, the daughter bought her mother a large-hole saltshaker and coarse-grained whole sea salt. The electrolyte regimen was resumed and within weeks her pain level subsided significantly. And then repeat neural therapy treatments became effective.

Interference fields are more than just local disturbances of the body's electrophysiology. They may also reflect the body's general electrical and energetic health, i.e. they may act as "canaries in the coal mine". Although neural therapy may be effective in the short run, taking steps to improve the patient's general health may be necessary for lasting benefits.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

Last month I mentioned briefly how vitamin B12 helped to improve a patient's response to neural therapy. In my experience this is not an unusual occurrence, so this month I want to discuss vitamin B12's role in neural therapy in more detail.

Vitamin B12 (or cobalamin) deficiency (with toxic metals, food sensitivities, malnutrition of various kinds, etc.) is on my short list of conditions that may impair or defeat neural therapy. Typically these factors come into consideration when a fading response to neural therapy occurs after an initially promising one.

The absorption, biochemistry and physiology of cobalamin is exceedingly complex and beyond the scope of this newsletter. It is still a hot topic, even though vitamin B12 was discovered almost 90 years ago. Considerable research continues, particularly with regard to genetic factors that influence its absorption and utilization.

A quick cruise through Pubmed using "vitamin B12 deficiency" as search words, leads me to two conclusions: (1) The major research focus of cobalamin deficiency is still hematological, (i.e. pernicious anaemia); (2) Cobalamin deficiency is a condition primarily of the very young and the old.

This does not fit with what I am seeing in my practice. I am finding vitamin B12 deficiency in all ages and rarely is the haemoglobin level affected. Most of my B12 deficient patients are suffering from fatigue, depression, chronic pain or soft neurological symptoms.

So, why the difference between the findings of medical academia and my practice?: This is a question I perhaps should have asked myself while in medical school 40 years ago.

I attended a medical school that prided itself on its academic excellence. Its teaching hospitals attracted exotic cases and the most advanced medicine of the time was available for them. However with the academic rigour came a certain snootiness. I remember being taught that the referring physician was a "quack" if vitamin B12 was being prescribed without proper investigation. (Country docs of the time often prescribed vitamin B12 injections as "pick-me-ups" for their tired patients). Whether the injections helped or not did not matter in this environment. They were quacks because they had not measured the vitamin B12 levels!

I did not question this orthodoxy until I came across a medical paper two decades later. In this article it was shown that vitamin B12 levels in the serum did not correspond to the levels in the central nervous system (*van Tiggelen CJM et al. Vitamin B12 levels of cerebrospinal fluid in patients with organic mental disorder. J Orthomolecular Psychiatry 12:305-311, 1983.*) Since measuring vitamin B12 levels in spinal fluid is not practical in most settings, one is left with a therapeutic trial to determine whether the patient needs vitamin B12. The country docs of yester-year were not so far off the mark!



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For neural therapy and advanced healing



Around the same time I learned of an unusual treatment for sub-deltoid bursitis - a series of intramuscular vitamin B12 injections (1000 mcg cyanocobalamin) daily for about a week. This works most of the time and is an especially attractive alternative if a patient has bursitis in more than one location in the body. But it also demonstrated that high-dose and frequent B12 injections are harmless, and a response is obtained within a few days.

So now my test for vitamin B12 deficiency is a therapeutic trial of daily cyanocobalamin injections (1000 mcg) for a week. I teach the patients to inject themselves and even the most needle-phobic seem to be able to do it.

If the patient does feel better, the interference field in question is often found to have disappeared. And if not, it is often possible to resume neural therapy with better chance of success. At the least, the patient may benefit from improved energy, mood and sense of well-being.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of Neural Therapy: Applied Neurophysiology and Other Topics

Dear Colleagues:

Last month I discussed vitamin B12's importance in the practice of neural therapy and some of the practical aspects of its use. What the discussion boiled down to was a recommendation that daily vitamin B12 injections should be given as a therapeutic trial whenever deficiency is suspected.

One of my readers, Dr Mason-Woods ND asked why I recommended cyanocobalamin, when methylcobalamin is a more effective and more physiological substance. He points out the advantages of the methyl form:

- no toxicity from the cyanide residue
- better absorption and retention in the tissues
- better for vision (the cyano form is ineffective in this application)
- helps in sleep regulation.

To answer Dr Mason-Woods' question: in an ideal world, methylcobalamin would be my first choice also. However (at least where I practice in Ontario, Canada) methylcobalamin is less available, is more expensive and is not covered by the seniors' drug plans. Cyanocobalamin has (in this jurisdiction and in the last year) become a non-prescription item, is inexpensive and can be purchased in 30 ml bottles in some supermarkets. For these reasons, I save methylcobalamin for exceptional circumstances.

The situation is similar to that of folic acid and folate. Folic acid, like cyanocobalamin, is a pharmaceutically engineered product. It is cheap and easily available, but folate is what is found in nature, is more effective and probably safer.

Before leaving the subjects of cobalamin and folate, I would like to share a "pearl", taught me by another colleague, Barb Powell MD. This has to do with unusual requirements of vitamin B12 and folate in some of our patients.

Last month I mentioned that after one week of vitamin B12 injections, the patient should either feel better, or not. If there is no improvement, B12 deficiency is unlikely to be the problem. However if the patient feels better, the next question is going to be: when should the injections be repeated?

The answer seems to be: whenever needed. Some patients will need a repeat injection in a few weeks; some will need repeat injections every two days. If the patient needs frequent injections there is likely an abnormal genetic defect in the body's handling of both cobalamin and folate - a methylenetetrahydrofolate reductase (MTHFR) pleomorphism. This is surprisingly common in patients with fatigue, depression, detoxification difficulties, and signs of B12 and/or folate deficiency. A history of thromboembolism or children with neural tube defect or congenital heart problems are additional clues. And a high serum homocysteine can be another marker.

Testing for MTHFR pleomorphism is commercially available, and in Ontario, Canada, is even covered by the government health insurance plan. It is tucked away in a panel of



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For neural therapy and advanced healing



genetic tests used in investigating thromboembolic disease. The thrombophilia panel includes two genetic variants: p.ALA222Val and p.Glu429Ala. If one or both are present, the degree of "folate dependency" (Dr Powell's term) can be estimated by whether one or both are present and whether the genes are heterozygous or homozygous.

If the patient is homozygous for one or both genes, he/she may require daily supplementation of dietary folate of 5 mgm/day or more, in addition to frequent doses of vitamin B12. The response to treatment may be slow. The full benefit of high dose folate may take six months or more to be evident. Both Dr. Powell and I have seen patients' general health and whole world view change with this simple treatment.

Neural therapy's most distinctive attribute is the detection and treatment of interference fields. However, the skilled neural therapist knows that simply treating interference fields can take one only so far. The health of the whole nervous system must be taken into account. Ensuring that the patient has adequate vitamin B12 and folate are key factors in optimizing the patient's health and his/her response to neural therapy.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Still Time Left - A reminder:

Introduction to Neural Therapy - November 12-13, 2010 - Ottawa, Ontario, Canada.

<http://www.neuraltherapybook.com/NTcourses.php>

Dear Colleagues:

The feedback from my e-newsletters is the main reason that I continue to write them, now for 5 ½ years. It is satisfying to know that they are being read, that they provoke discussion and sometimes raise questions. A recent letter is an especially interesting one, because it is coming from a physician who is already practicing neural therapy at a reasonably advanced level (judging from his use of sphenopalatine and vagus nerve blocks):

Dr. Kidd,

I have an unusually tough neural therapy case I'm hoping that you'll be willing to discuss with me. I am treating a woman with right -sided sublingual pain that manifested during a Lyme infection eight years ago. I continue to get temporary results (up to one week) with Vagus and Sphenopalatine ganglion shots, and improved my outcomes by adding B12 to her regimen. I suspect that mercury in her mouth may be thwarting my efforts, but I am unable to connect the mercury to her condition using my applied kinesiology testing.

I felt that this question warranted a telephone call. (The physician-correspondent lives in the North Eastern US). I was at first puzzled that he was obtaining responses to neural therapy of the sphenopalatine ganglion and vagus nerve, and not the submandibular ganglion, but that was indeed what he was getting. And he has been getting these responses repeatedly.

Until proven otherwise the limited duration of the responses is indeed due to the mercury from the patient's amalgam fillings. Mercury diffuses readily into the oral tissues and can be sequestered there for a long time. Mercury should be considered a contributing factor to any interference field in the head and neck, in patients with (or who have had) amalgam fillings. Simply put, mercury makes nervous tissue irritable and electrically unstable.

Upon questioning our correspondent's applied kinesiology testing method for mercury, he explained that he was "two-pointing" for interference fields in one or more of the nearby amalgam-filled teeth. This was not an unreasonable idea, as ganglion interference fields often do have associated interference fields in the area that the ganglion "covers". However any toxic effect on a ganglion can and should be tested for in a more direct way.

The most direct method is to simply:

1. put a finger on the interference field and test for indicator muscle strength;



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2. put a specimen of the toxin on or near the patient (a mercury thermometer works well for mercury);
3. repeat the strength test of the indicator muscle;
4. look for a change in strength.

If the muscle strength changes - weak to strong or strong to weak - because of the presence of the toxin, we can be confident that the toxin is affecting the interference field.

If no response occurs, and the toxin is still suspect, one can try challenging with an antidote to the toxin. In the case of mercury, DMPS or DMSA will often work. (Put them on or near the patient in the same way as with the toxin).

Occasionally a substance that is needed in the detoxification process, e.g. vitamin C, electrolytes, chlorella, selenium, a glutathione precursor or glutathione itself, will cause a change in indicator muscle strength. If a change occurs, one can then try to reverse the change by introducing a second challenge to the scenario, i.e. if vitamin C makes the indicator muscle go strong, and adding mercury into the field makes it weak, one can deduce that the patient will benefit from supplemental vitamin C, and the reason for this abnormal need is mercury toxicity.

Toxic effects on interference fields can be complicated. As in our correspondent's patient, vitamin B12 supplementation helped to a degree. However vitamin B12 deficiency is generally associated with many other nutritional, immune and toxic disturbances.

For example, multiple large amalgam fillings are often a result of dental enamel hypoplasia (soft teeth), associated with gluten sensitivity. With gluten sensitivity comes malabsorption and vitamin B12 is only one of many nutritional possibilities. In the gluten sensitive, gluten can be a neurotoxin, adding further irritability to the patient's interference fields.

In my experience the most challenging part of neural therapy is not the finding and treating of interference fields, but rather the maintaining of a good response once the interference fields have been found. This often takes time, experimentation and patience but the results can be rewarding for both physician and patient



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

This month I would like to report an interesting case I saw in my office demonstrating the effect of interference fields (and their treatment) on body chemistry.

An otherwise healthy 65 year old man presented with numbness and tingling of his right hand of 8 years duration. His problems began with an ice-hockey injury in which he was hit from behind, immediately developing pain in his left neck and numbness in his right arm. The arm was "completely numb" for about 15 minutes.

From that time he was unable to lie on this left side and had difficulty rotating his head towards the left. At first tingling was present in his hand only when shaving, but in the last 4 years the tingling was disturbing his sleep.

A diagnosis of carpal tunnel syndrome was made, but surgery only lead to spreading of the numbness to involve his four medial fingers. Relief could be obtained while lying on his left side by pronating his right wrist and positioning the arm behind his torso.

Examination revealed restriction of rotation of his neck towards the left, severely restricted craniosacral motion of the ethmoid and arcing in the thoracic diaphragm and the occiput. (These physical findings were consistent with injury to the cervico-thoracic junction and occiput.) An interference field was detected by autonomic response testing in the left sphenopalatine ganglion. The somatic dysfunction was treated using osteopathic manual techniques and the interference field was treated with the Tenscam device. (An alternative treatment would be to inject the ganglion with procaine as described on page 181 of my book available at <http://www.neuraltherapybook.com/>.)

One month later the patient reported no change in his symptoms. However something strange had happened. The metal upper (contact) surface of his upper partial denture had turned white within a few days of the treatment.

This lead me to suspect that the denture had something to do with the patient's condition, perhaps setting up the sphenopalatine ganglion to become an interference field. In fact, when the denture was removed, autonomic response testing, which was blocked, suddenly became unblocked and craniosacral motion of the whole body went into a still point. The body was obviously relieved to be free of this stress.

This lead to the next question: What was it about the denture that was causing this reaction? I suspected a reaction to a metal because of the discoloration of the upper surface. Autonomic response testing indicated that chromium was the reactive metal.

A sample of blood was sent to the Clifford Lab (<http://www.ccrlab.com>) in Colorado to test for sensitivities to dental materials. In the meantime, the patient learned from



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his dentist that the plate did indeed contain chromium. And a few weeks later the lab report confirmed that the patient was sensitive to chromium.

The patient is now proceeding to have another denture made without chromium. At this point, I do not know if this measure will solve the hand numbness problem, but I suspect that in time it will. Chromium is known to be allergenic and there is some evidence that it is neurotoxic, although surprisingly little research has been published on this subject.

Interference fields in the sphenopalatine ganglion, although usually associated with facial and dental problems, can have widespread effects. I remember once seeing a woman with total body pain of several years duration caused by a sphenopalatine ganglion interference field.

However the most interesting part of this story for me was the change in colour of the metal plate. Clearly there was a change in chemistry of the upper palate from neural therapy of the sphenopalatine ganglion. That interference fields are associated with altered blood chemistry is not a new idea. The Austrian physiologist Pischinger and his colleagues explored this phenomenon during the 1960s and 70s. They discovered that interference fields cause changes in pH, oxygen saturation, electrolytes, cholesterol and other chemical and haematological parameters on the side of the body in which the interference field is present. Treatment of the interference field reverses these changes.

The healing effect of neural therapy is still mysterious in many ways. We know that treatment, whether by procaine injections, by electrical or by energetic devices, alters electrophysiology and changes autonomic nervous system tone. This case demonstrated in a clearly visible way that changes in biochemistry also occur.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

Neural therapy is unique in Western conventional medicine in its focus on regulatory mechanisms, specifically those involving the autonomic nervous system. For this reason it is sometimes called "Regulation therapy".

Of course a healthy body regulates itself. Under normal circumstance, it should not need any external assistance. It is only when proper regulation is not occurring that problems arise; then the physician needs to seek out why.

Systemic breakdowns of autonomic nervous system function do occur. These are rare, are often related to genetic disorders and are called by neurologists "dysautonomias".

On the other hand, localized autonomic nervous system dysfunction is common. The cause is always an "interference field", and this is the goal of neural therapy: to search out and treat interference fields. If the overall health of the patient is otherwise good, treatment of the interference field will nearly always restore normal function.

However not all regulation occurs at the level of the autonomic nervous system.

The body has numerous regulatory systems, from the sub-cellular to the systemic. The purpose of regulation is always to provide homeostasis, i.e. a stable physical and chemical environment at whatever level the regulation is operating. If this regulation fails, (parameters deviating higher or lower than optimal), an "off-balance" (Revici's term) is said to have occurred. (A brief discussion of this concept can be found in my book <http://www.neuraltherapybook.com> on pages 27 & 28).

The counter-intuitive part of this idea is that both a high or low deviation from the norm can mean the same thing. (And a deviation can "flip" from high to low, or vice-versa.) Both a high or low body temperature can mean that the body is fighting an infection. Dosch's textbook reports that interference fields can have either lower or higher electric potentials than that of the surrounding tissues. This principle holds true for certain blood parameters as well. Both low and high serum sodium concentrations can mean dehydration, (and salt deficiency). This may also be true of serum cholesterol levels. I want to present a case that demonstrates this.

But before doing so, a few words about serum cholesterol (and serum triglycerides) and their relationships to gluten sensitivity: In a previous newsletter (<http://www.neuraltherapybook.com/newsletters/> Vol.2 No.9 September 2007), I explained how poor response to neural therapy can often be explained by exposure to gluten in a gluten-sensitive individual. Gluten sensitivity is common and manifests in many different ways, gastrointestinal distress being only one. Diagnosis is too big a subject to be discussed in detail here, but there are a couple of serum markers that I find useful as "red flags". One is a low serum triglyceride (<1.25 or 50); the other is a low serum cholesterol (<4.0 or 160) (and



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especially the LDL cholesterol (<2.5 or 100)).

An easy explanation for these low parameters is fat malabsorption in the small intestine. Malabsorption is a hall-mark of gluten sensitivity, although in most individuals it is mild. However there may be other mechanisms at work because in many gluten sensitive patients, their serum cholesterol levels are high. I take this as being a non-specific response to stress, as cholesterol levels can increase for many reasons. It is interesting that in mice experiments, salt restriction has been shown to elevate cholesterol levels.

But back to my patient: This 60 year old female patient came to me for a second opinion about a high cholesterol level, for which her family physician was recommending cholesterol-lowering drugs. The cholesterol level was only mildly elevated (6.81 or 263), with an LDL of 4.66 (or 172). There was little family history of coronary disease and almost no other risk factors.

She did however complain of fatigue, headaches, fluid retention, gastro-esophageal reflux and vaginal dryness. Her mother had died of pancreatic cancer. For these reasons I suspected underlying gluten sensitivity and had her do an enterolab test <https://www.enterolab.com/Home.htm> which was positive for antigliadin antibodies.

Looking back on her blood chemistry from 13 years before, she had very low LDL cholesterol levels. Clearly she had been under gluten-induced stress even then.

A gluten-free diet, some nutritional support, a little bio-identical estrogen and DHEA and 6 months later her serum cholesterol dropped to 6.16 (238), and LDL to 3.99 (154). She was also feeling better in many respects.

The lessons from this story? For good results in neural therapy, regulation is important at all levels. Gluten sensitivity needs to be identified and treated. Low cholesterol (and triglycerides) can mean gluten sensitivity, but so can a high cholesterol. And cholesterol values can "flip"!



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

I would suspect that most of you experienced in neural therapy know the "thrill of the hunt" - hunting not for antlered animals, fast flying fowl, or flitting fish, but for those invisible interference fields! Searching for interference fields requires knowledge, skill and a certain amount of intuition, just as in hunting for prey.

In this newsletter, I want to make a quick review of different methods of detecting interference fields and then introduce a new technique which I have learned in the last year. I suspect it will be new to most of you, but not to all. That is because I learned it from my friend and colleague, Dr. Carlos Chiriboga of Guayaquil, Ecuador. My guess is that many South American readers and a few others will already be familiar with it.

But first the review: The search for interference fields always begins with a careful history. The most important clue is to find an injury, illness, or medical procedure - followed by a latent period of a few weeks - before the onset of the patient's symptoms. The triggering incident might seem inconsequential to the patient, or even be half-forgotten, but this may lead the physician directly to the interference field. (For more on history taking, see pages 34-36 of my book available at <http://www.neuraltherapybook.com>).

Physical examination will occasionally provide clues. This should be part of the general examination, paying special attention to changes in skin color, temperature and moisture, tenderness in scars and sites of soft tissue injury, signs of inflammation and the complications of prosthetic dentistry. Autonomic response testing, in its many forms will localize interference fields precisely. (See chapter 4 of the above mentioned book).

Sometimes the patient's history is so complicated (e.g after major accidents, multiple surgeries or illnesses), that it is hard to know where to start. Here we need some sort of scanning technique to get an overall view of the body.

For those skilled in osteopathy or other manual skills, energetic techniques can be helpful. With careful attention, pulsations can be felt with the hands on or off the body emanating from interference fields. Alternatively, interference fields can be "visualized" with the physician's "mental eye". In my experience these techniques work best detecting the larger interference fields, such as organs, the diaphragms, or areas of blunt trauma.

This new (to me) technique that I have promised to share involves palpating the radial pulses of each forearm. Dr Chiriboga calls it the VAS, or Vascular Autonomic Signal; Dr Nogier (of France) called it the RAC, Reflex Autonomic Cardiac test. The examiner's three middle fingers are placed on the radial artery with the index finger just below the radial styloid. The amplitude of the pulse is graded under each fingertip on a scale of 1 to 3, three being the strongest.



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Each fingertip represents a zone of the body, the 2nd the head and neck, the 3rd the mid-body and the 4th the pelvis and leg - for that side of the body. (*Vatta*, *Pitta* and *Kapha* are the names-from Ayurvedic medicine). Where the pulses are weak, interference fields will be found. If the sum of the scores of all six pulses is 8 or less, an "energy leak" is said to be present. Energy leaks typically occur at sites of major trauma or at chakras. For those knowledgeable about osteopathy, the chakras generally correspond to the diaphragms. Manual techniques can repair these leaks.

I am always loath to teach a new technique or idea until I have tried it for some time myself. Dr Chiriboga taught me this last February and after a year of testing, I am now satisfied that it is a reliable and useful tool for zeroing in on the areas where interference fields are likely to be found.

I particularly like this technique because it takes no extra time. I always check my patients' pulse as part of the general examination. (A fast regular pulse indicates sympathetic dominance; a slow irregular one, parasympathetic dominance.) VAS evaluation can be done simultaneously. While counting the pulse, the strength of the pulse under each testing fingertip can be assessed and scored.

I recognize that practitioners of oriental medicine obtain a great deal more information from pulses than I am presenting here, but for Western-trained physicians, this is an easily learned and useful technique to help find those elusive interference fields.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

Almost 5 years have passed since I last discussed **the relationship between neural therapy and prolotherapy**. (See <http://www.neuraltherapybook.com/newsletters/1-2.php>.)

A recent case in my office suggests it is time for another look.

A 33 year old man presented with pain in his head, neck and upper back for 6 years (as a result of a rear-end motor vehicle accident). He also had developed lower back pain radiating into both legs, associated with gastrointestinal symptoms in the previous year.

The upper trunk symptoms were the result of soft tissue injuries and responded (to a degree) to physiotherapy, manipulation and exercise. However improvement had plateaued and after five years the attending physician suggested a trial of prolotherapy. The patient was referred to a very experienced prolotherapist who provided eight sessions of prolotherapy, four to the cervical region and four to the upper thoracic spine.

The patient experienced some post-injection pain and improvement in upper body mobility. However, the post-injection pain worsened with time; pain gradually began to develop in his low back and legs; and constipation, anal itching and hemorrhoids appeared - entirely new symptoms.

He ascribed the changes in gastrointestinal function to side effects of analgesics and underwent rubber band ligation (banding) of his hemorrhoids with some relief. However this helped neither the constipation nor the lower body pain.

Musculoskeletal examination was unremarkable with good body symmetry and muscle balance. Using autonomic response testing, an interference field was detected at the anus and treated with a Tenscam device. (The classic neural therapy technique is injection of dilute procaine as "quaddles" into the skin in a circle about two inches from the center of the anus).

The result was immediate relief of all lower body pain and gastrointestinal symptoms for about five weeks. Little or no change occurred in the upper body pain.

On re-examination at six weeks, autonomic response testing revealed a recurrence of the anal interference field. This was treated and because of the persisting upper body symptoms, a closer examination of the upper body was undertaken. A restriction of cranio-sacral motion and interference field was detected at the bridge of the nose (site of an old injury) and was treated with a cranial osteopathic technique. (An alternative treatment would have been neural therapy - either quaddles, Tenscam or possibly laser treatment).

Four weeks later the patient reported little change; the lower body pain had not returned, but the upper body pain persisted. However a change in musculoskeletal



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balance had occurred and "arcing" (a subtle pulsation from a specific locus) could be felt in the upper thoracic region. This was treated with an osteopathic unwinding technique and after 12 hours of increased pain, a significant physical and emotional release occurred. The patient felt (for the first time) marked relief from the upper body pain and a change in upper body posture. The patient described it as feeling "like before the accident".

So why did the prolotherapy trigger such an unusual response? One can only speculate, but a few neural therapy principles may help explain it.

Firstly, neural therapy and prolotherapy are more similar than generally recognized. It puzzles me that in all the published research on prolotherapy, the role of procaine or other caine anesthetics has never (to my knowledge) been examined. Yet a caine anesthetic is always part of the injection solution.

Secondly experienced prolotherapists know that some patients respond very quickly to prolotherapy - immediately or within days. This cannot be due to the proliferant effect which takes weeks or months for full benefit. The procaine is the only possible explanation for this rapid response.

Thirdly, occasionally neural therapy injections will temporarily worsen a patient's symptoms. Experience has shown that this sort of response means that another important interference field is present. It should be searched for vigorously as it is often the key to solving the patient's problem.

My interpretation of this man's unusual reaction to the prolotherapy was that the body was reacting as if the prolotherapy were neural therapy directed at the wrong place. The worsening of symptoms suggested that an important interference field was somewhere present. What is harder to explain is the persistence of the post-injection pain. It would seem that the proliferant effect must have been playing a role, as the process is known to carry on for many months.

I am not entirely sure how this persisting pain can be explained and welcome readers' opinions (no matter how speculative) for a solution. Whatever the mechanism, I think it worth reminding ourselves that whenever unusual pain is experienced during or after prolotherapy, it is worth looking for undetected interference fields.



Volume 6, No. 4, April 2011

NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues,

I would like to devote this month's newsletter to some "news" - a report on a recent neural therapy conference in Guayaquil, Ecuador.

As some of you may remember, **Dr. Carlos Chiriboga** of Ecuador spoke at a small neural therapy conference in Canada about a year ago. He also spent two days in my office where we compared various examination and treatment methods. For those of you who are interested, this was reported in a newsletter last

year: <http://www.neuraltherapybook.com/newsletters/>
(Feb. 2010 Vol 5).

As stated here before, South America has become the place to watch when it comes to neural therapy. It is widely taught and practiced; literature and books are being published (in Spanish); and large educational meetings are held. This particular one was convened with only one month's notice. Over 80 physicians attended, some flying in from Costa Rica, Columbia and Argentina - such is the interest in neural therapy!

What made the meeting special was the meeting of minds from the English and Spanish speaking worlds of neural therapy. Of course both schools of thought can be traced back to the Huneke brothers of Germany. But it became apparent to me that these traditions have developed somewhat differently in North and South America.

For example, the most experienced neural therapists in Latin America are using the original Huneke formula ("*Impletol*") of procaine 2% + caffeine 0.25% for injections. In North America, plain procaine ½ % or less, appears to be the standard.

Dr Fernando Pinto of Quito delivered a lecture on the rationale for the inclusion of caffeine, using historical, scientific and philosophical arguments. However it was pointed out that Latin Americans continue to discuss the advantages and disadvantages of different formulations to this day.

Some of the neural therapy being conducted is (by North American standards) quite heroic - following in the footsteps of the early pioneers described in Dosch's textbook. Dr Cardenas, also of Quito, is treating Parkinson's disease by injecting (among other sites) carotid and vertebral arteries. A before-and-after video clip of a patient with severe Parkinson's gait was impressive.

I have found that in general the South Americans that I have met have little knowledge of osteopathy, a related discipline that shares many ideas with neural therapy. However Dr Eduardo Granja presented an interesting lecture on the use of Chapman points as entry spots for neural therapy into the autonomic nervous system. (Chapman was an American osteopathic physician, famous for his description of skin points that relate to internal organ function.)

One other interesting area of contrast was methods of testing for interference



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fields. Even though George Goodheart DC had a direct influence on the development of Latin American neural therapy, the preferred method of testing appears to be Omura's bi-digital O-ring test. In North America the most popular method is autonomic response testing, a variant of Applied Kinesiology developed by Dietrich Klinghardt and Louisa Williams.

Dr Carlos Chiriboga lectured on common interference fields associated with orthopaedic conditions. Many of these relate to acupuncture points. I was particularly intrigued by his observation that de Quervain's tenosynovitis is often caused by large bowel interference fields.

Charles Crosby DO of Orlando spoke on scalar energetics and demonstrated his invention, the Tenscam device. I lectured on "Three Ways of looking at interference fields" and "Toxicities Affecting Neural Therapy".

There is no doubt in my mind that the South American neural therapists' knowledge and experience of neural therapy is much deeper than ours in North America. After all, neural therapy was brought to South America in the 1960's by Julio César Payan and Germyn Duque, who had both studied directly under the Huneke brothers. It was 20 years later that Dietrich Klinghardt brought neural therapy to North America.

However, I believe that North Americans have something to offer South Americans in neural therapy. One is the rich tradition of autonomic nervous system knowledge that comes from osteopathy. Another is expertise in "functional medicine", the metabolic, nutritional, immunological and other factors that so influence the effectiveness of neural therapy. The modern neural therapist needs these skills!

I have not yet touched on another related area of medicine where South Americans and North Americans have much to teach each other. That is the world of "energetics". Perhaps that will come in another newsletter!



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

Last month I intimated that North and South American neural therapists may have something to teach each other about the world of energetics. This was based on what I learned at a recent conference in Ecuador on neural therapy. For those of you who missed my report see Vol. 6, no.4, March 2011: <http://www.neuraltherapybook.com/newsletters/>.

But to put South American energetics into perspective, I first need to say how impressed I was that neural therapy in South America is practiced along very traditional lines. The Huneke brothers are still held in high regard and their names are mentioned often. When neural therapy is discussed, the term used is "neural therapy according to Huneke". This appears to be the convention in Germany as well, judging from the title of Dosch's textbook, *Manual of neural therapy according to Huneke*.

This homage to the Hunekes reminded me of the osteopathic profession's ongoing respect for AT Still, the founder of osteopathy. In osteopathic circles, hardly a lecture is given without a tip of the hat to AT Still. This is because both AT Still and the Huneke brothers were more than astute clinicians; they had the ability to communicate a whole new way of seeing pathophysiology. Their greatest gifts to those who followed them were their medical perspectives. They were above all else thinkers!

Having said this, some, but not all South American neural therapists are using energetics in diagnosis, although not in therapy. As mentioned last month, the bidigital O-ring test is commonly used to detect interference fields. The treatment is however, procaine injections. Energetic testing for factors inhibiting neural therapy, such as nutritional deficiencies, food sensitivities and toxic metals does not appear to be routinely done.

In a parallel development, some South American neural therapists have embraced a sophisticated form of energetics called Sintergetica medicine. This system is the creation of Dr. Jorge Caraval, an influential Columbian physician, teacher and author of numerous medical books. As the name suggests, ideas from a variety of healing traditions (Chinese, Tibetan, Ayurvedic, South American shamanistic and Western medicine) have been synthesized and applied using VAS (vascular autonomic response) in diagnosis and soft lasers in treatment. These specially made lasers use a variety of complex frequencies in both diagnosis and treatment.

Sintergetica medicine attempts to integrate all aspects of an individual's being including gross and microscopic anatomy, metabolism, circulation, energy patterns and flow, temperament, emotions, psychic factors and "ancestral energy" (presumably the energetic phenomena observed in family systems therapy or in morphogenetic fields). Drawing as heavily as it does from Eastern spirituality, it should not be surprising that the perspective



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is decidedly New Age <http://www.sintergetica.com> and may not be entirely acceptable to those with a Judeo-Christian world view. Nevertheless many interesting observations can be found that have potential application to Western medicine including neural therapy.

The most intriguing part of this system (for me) is its correlation of specific frequencies with many aspects of an individual's identity, including levels of consciousness, personality, metabolism, gross and microscopic anatomy, etc. This information is incorporated into a chart (See below) which bears some resemblance to the periodic table. The rows ("bands" in Synergetica) correspond to the Nogier frequencies in the ELF range. (Acupuncture meridians and homeopathic remedies resonate in this range.) The columns correspond to higher frequencies that are superimposed on the lower ones, just as sound frequencies are carried on radio waves. Colour indicates relationships between the specific frequencies.

For example, the level of the rows corresponds with (among other things) levels of consciousness: the lower 3 being subconscious, the 4th transitional, the 5th and 6th conscious, and the 7th "transpersonal". Rows generally correspond with character, columns with temperament. At the same time, anatomy is also addressed; each specific frequency corresponds with a spinal segment (shown on other charts).

As in homeopathy, multiple aspects of an individual's constitution are taken into account. However synergetica goes much farther, applying somatotopic principles and treatments not just to the patient's constitution but (potentially) to every part of the body.

Synergetic medicine is a very different world than neural therapy. However the energetic techniques that facilitate neural therapy (autonomic response testing and Tenscam) indicate there is overlap. I look forward to the day that Dr. Caraval's ideas become available in English.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

This month, I would like to discuss one of the most frustrating and embarrassing conditions that may befall the human body. That is - **fecal incontinence**.

In the US, approximately 1 of 12 adults suffers from this condition. Generally speaking, its incidence increases with age but **it cannot be considered a result of aging alone**. Its causes are many, including trauma, medical, neurological and psychiatric conditions. Commonly it is associated with diarrhea and/or constipation.

Trauma affecting bowel control includes that of childbirth, anal surgery, radiation, or the irritation of chronic hemorrhoids. **Neurological causes** include cerebrovascular accidents, multiple sclerosis and Parkinson's disease. Fecal incontinence may be associated with **irritable bowel syndrome** and **chronic obstructive lung disease**.

However in some patients none of the above applies. Fecal incontinence develops for less obvious reasons. Since **bowel control is intimately connected to autonomic nervous system function** this aspect needs to be considered, at least in some of our patients. This is true even for those with "weakened" pubo-coccygeal muscles. The "weakening" may be due to autonomic nervous system inhibition and therefore be easily reversible.

Here is an example seen recently in my office:

An otherwise healthy 71-year-old woman presented with 3 years of intermittent fecal incontinence. This was occurring on average twice a week at irregular times and on two occasions in bed at night. Sometimes an involuntary movement occurred within hours of her usual morning bowel movement.

Bowel movements were often loose and sometimes associated with mucus. A stool analysis showed no abnormality; therapeutic trials of cholestyramine and Sennekot were ineffective.

Past trauma included hemorrhoid surgery in her 30s, a motor vehicle accident at age 54 in which she sustained a fractured femur (requiring surgery) and a bowel perforation. She had had 4 uneventful pregnancies and deliveries. She was on no medication, had no allergies and considered her energy level to be high.

Medical examination revealed a healthy-looking woman who appeared younger than her stated age. Her general examination was unremarkable. However examination of her musculoskeletal system demonstrated restriction of neck rotation to the left, considerable limitation of shoulder movement bilaterally (she had chronic shoulder



"bursitis"), and a **right innominate upslip (or superior innominate shear)** associated with right psoas muscle tightness. Craniosacral movement was severely restricted over the sacrum, cranial vault and temporal bones.

Vascular autonomic response testing showed almost non-existent Kapha pulses (See newsletter Vol, 6, No. - February 2011 at <http://www.neuraltherapybook.com/newsletters/>) on both the right and left sides of the body. This indicated a major autonomic nervous system disturbance in the pelvis or legs.

"**Arcing**", (a pulse emanating from a locus of previous trauma or an interference field) could be felt from the pelvic floor. This was treated using an osteopathic unwinding technique. The result was a complete resolution of the pelvic somatic dysfunction.

Autonomic response testing was used to search for interference fields in the pelvis (anus, pre-coccygeal ganglion, pelvic plexuses), the surgical scar in the leg, the abdominal viscera and teeth. An interference field was detected at the C5 vertebra and treated with the Tenscam (an energetic form of neural therapy).

A month later, the patient reported a complete resolution of her fecal incontinence.

I have often taught that neural therapy (according to Huneke) and osteopathic manipulation are different methods of treating the same thing. **Somatic dysfunction behaves in exactly the same way as interference fields do and in my opinion should be considered a form of interference field.** In this case an interference field was found in the cervical spine, but I am doubtful that it had a significant role in the patient's response. The VAS, the "arcing" and the somatic dysfunction all pointed to a major disturbance in the pelvis. In addition, there were likely "tissue memories" from the remote hemorrhoid surgery and possibly the bowel perforation.

For those not familiar with osteopathy, an innominate upslip (or superior shear) is a slight cephalad displacement of one innominate bone relative to the rest of the pelvis. It is often (but not always) a result of trauma, e.g. a fall on a buttock. Low back, or any other sort of pain does not necessarily occur. However as with all somatic dysfunction there is an autonomic nervous system component, as in this case, affecting the lower bowel.

When teaching osteopaths, I like to say "**neural therapy is osteopathy by other means**". Neural therapists can benefit by knowing that "**osteopathy is neural therapy by other means**"



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For neural therapy and advanced healing



Volume 6, No. 7, July 2011

NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

It is always a pleasure to report on something new in the (English-speaking) world of neural therapy. This month I want to briefly review a recently published book: "Beyond pills, knives and needles" by Charles Crosby DO, the inventor of the Tenscam.

First, full disclosure: Dr Crosby is a personal friend and I have written the Foreword to this book. I have no financial interest in it but I have for many years been intensely interested in the Tenscam device, its application to neural therapy and the science that lies behind it.

The book is divided into two parts. The first is a survey of the science that underpins the energetic understanding of human health and disease. The second is practical applications of the Tenscam device. The first half is the important one, from the point of view of those practicing neural therapy.

The most valuable contribution of this book to the world of neural therapy is a new definition of the term "interference field".

The term interference field, as coined by the Huneke brothers is a clinical definition - a focus somewhere in the body causing local or distant dysfunction, that responds to local injections of procaine. Because procaine was involved from the beginning in the discovery of interference fields, and because it is a sodium channel blocker, interference fields have been seen (up to now) only in electrophysiological terms. Simply put, **interference fields are local disturbances of the body's electrophysiology**

This definition has served us well. It provides physiological and anatomic explanations for our treatments. It also helps us understand the limitations of neural therapy and forces us to explore other aspects of physiology that make neural therapy more effective. (See "generalized cell membrane instability" Sept. 2007 <http://www.neuraltherapybook.com/newsletters/>).

However in recent years, the concept of "energetics" has been appearing more and more in the marketplace of ideas. Energetics has always been an explicit part of Eastern and shamanistic medicine, but in Western medicine its presence has been mostly "under the surface". Only with the advent of quantum physics has it become respectable to speak about non-local effects, resonances, intentionality and so forth.

Experimental and clinical evidence is demonstrating that the body has a field of energy encompassing it and disturbances of this field are associated with detrimental effects on the health of the body. Dr Crosby takes the bold step of referring to these "disturbances or areas of anticohereance" as "interference fields". How well this definition correlates with the classical (electrophysiological)



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one is not discussed in this book, but my personal experience would say that the correlation is reasonably close. I suspect that there are exceptions, but I will leave that discussion for another day.

Dr Crosby also introduces some other concepts that affect the body's energy field, for good and for bad. His descriptions of the Schuman resonance, crystals and scalar energy are particularly clear and concise. In my opinion the book is worth reading for these alone.

Another new idea is Dr Crosby's personal method of detecting interference fields energetically. Using ideas from Jean Pierre Barral, (the guru of visceral manipulation), his hands scan the patient's energy field at a distance of 18 to 24 inches from the body, looking for "troughs" or "spikes" in the field. This is a quick and easy way to scan for the bigger interference fields, but does not (in my opinion) have the precision needed to localize very small interference fields, as in teeth, or in a part of a tooth. Fortunately, he also describes autonomic response testing and other methods which can complement this scanning method.

The second half of the book describes the wide variety of disorders that can be treated energetically, and specifically with the Tenscam. Little of this will be surprising to experienced neural therapists, but nevertheless I found pearls here and there. Dr. Crosby fearlessly treats fibromyalgia, cardiac valvular dysfunction, and hernias, conditions not usually considered amenable to neural therapy. He also treats problems due to unresolved emotional conflicts by applying Tenscam energy to an area a few inches superior-posterior of the right ear. Little is provided to explain the rationale for this last treatment, but given the lack of risk it would seem reasonable to try this in appropriate patients.

This readable little book can be ordered by email at <mailto:orders@bookmasters.com> or by telephone (in the US) at (800)247-6553 or (outside the US) at (419)281-1802 Ext 2402.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

This month I would like to discuss the prostate gland: that unsung hero of reproduction and the bane of middle-aged and older men.

Most men don't even know they have one until something goes wrong -in younger men it is usually prostatitis, and in older men benign prostatic hypertrophy (BPH) or cancer. This is a large subject for a small newsletter, but one that should not be avoided, as neural therapy can be very helpful in these hard-to-treat conditions.

"Prostatitis" is poorly understood. Although inflammation is clearly present in many cases, the cause is not always easy to find, and some cases may actually be pain syndromes related to pelvic floor muscle imbalance. For an excellent review of the causes of "prostatitis" see: <http://www.prostatitis.org/causes.html>.

Conventional treatment is hit-and-miss, perhaps because diagnosis is often unclear. But even in those cases where bacterial infection is identified, antibiotics are frequently ineffective. This should not come as a surprise as chronic infections in other parts of the body, e.g. abscesses or dental infections often cannot be reached by antibiotics.

Benign prostatic hypertrophy (BPH) and prostate cancer can occur separately but probably more commonly exist together, whether the cancer is identified or not. 50% of men in their sixties have symptoms of BPH (urinary frequency, urgency, dribbling or retention) and 60% have cancer cells in their prostates (as found in autopsies for unrelated reasons). The vast majority of these cancers are asymptomatic and never create problems.

The causes of both conditions are complex and probably multifactorial in most cases. Hormones are important. (For example BPH does not develop in eunuchs.) Both dihydroxytestosterone (DHT, a metabolite of testosterone) and estradiol are believed to promote BPH and prostate cancer. However the interrelationships of these and other hormones are complex. Reducing DHT levels with 5-alpha-reductase inhibitors such as Proscar or saw palmetto is a common goal of treatment, but some authorities believe that DHT can actually increase estradiol levels by shunting testosterone metabolism from DHT towards estradiol.

Hormonal balance is important, but toxins accumulating in the prostate are believed to also contribute to BPH and cancer. Pesticides, toxic metals (especially cadmium) and certain organic solvents have all been associated with prostate cancer. In my experience, autonomic response testing often detects these toxins in association with interference fields in the pelvic plexus or prostate.

Whatever the cause, if interference fields are detected, neural therapy is often, (but not always) effective. In my experience treatment must be repeated



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frequently, taking months, and sometimes years for resolution. Neural therapy's beneficial effect is probably related to opening up circulation to the prostate - thereby improving its nutrition and excretion of wastes. In most cases, interference fields are found in one or both pelvic plexuses (Frankenhauser plexuses), but sometimes only in the prostate itself.

Treatment of pelvic plexus interference fields by injection is outlined on page 190 of my book, available at <http://www.neuraltherapybook.com/>. (An alternative method is to use the Tenscam device.) The prostate can be injected directly through the perineum. This is technically easy and safe; the technique is described on page 133 of Mathias Dosch's book: Illustrated atlas of the techniques of neural therapy with local anesthetics.

Homeopathics can be injected with the procaine, or alternatively the Tenscam can be used passing its scalar energy through an appropriate vial of homeopathic. Autonomic response testing should be used to guide the choice of homeopathic.

A brief note about cancers: The Dosch Manual of Neural Therapy According to Huneke takes pains to say: "Cancer is not curable by neural therapy alone". There is some wisdom in stating this at the outset, given the emotional connotations of the word cancer, and the sometimes desperate hope of its victims for a magical cure. Because many patients are unfamiliar with neural therapy, it is probably best to understate its role in treating cancer.

However if we think of cancer to be (at least in part) a localized failure of immune function, neural therapy can play a role in optimizing the body's physiology in the region of the cancer. Dosch's textbook has an interesting discussion (pp. 148-150 in the most recent edition) of the theoretical basis for using neural therapy in treating cancer.

I remember one man in his late 50's with a Gleason 7 prostate cancer and a toxic prostate from many years exposure to xylene in a fiberglass factory, who responded well to neural therapy and an organic solvent detoxification protocol. Twelve years later he is alive and healthy.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

I don't usually think of the skin (or a portion of it) as being a potential interference field. But last winter I had an otherwise healthy 37-year old dairy farmer present with an allergic dermatitis that turned out to be caused by not one, but by two interference fields in the skin.

His problem had begun a year previously when he sustained a blunt injury to his right thumb which subsequently became infected. He was prescribed an oral antibiotic and another medication, to which he reacted with severe swelling of his eyelids, swelling and blistering of both arms and eventually a rash which spread to involve most of the upper half of his body.

Skin patch testing identified allergy to black rubber (as in tires) and diesel fuel. Although his symptoms settled with time, even very slight exposure to these chemicals provoked a skin rash beginning at the anterior surface of his right wrist (not at the thumb).

This hypersensitivity was a major inconvenience to him as a farmer. Even during milking he had to wear protective gloves because of the black rubber hosing on the milking machines. Despite these precautions, "flares" of skin reaction occurred from time to time affecting his right arm and other parts of his upper body.

His past history was unremarkable, except for intermittent mild eczema from childhood, a right inguinal hernia repair in infancy, pneumonia at age 14 and wisdom teeth extractions at age 23. Five years previously his right arm had "swelled up" from a reaction to a "fake tattoo" on his right upper lateral arm.

Physical examination revealed a vigorous, healthy man with an unremarkable general medical examination. His musculoskeletal system showed no asymmetry, unrestricted range of motion of all major joints and at all spinal levels and good muscle balance. Autonomic response testing showed blocked regulation and an interference field at his right anterior wrist. The response was reversed with the presence of procaine and DMSO. (DMSO or dimethylsulfoxide is considered the "universal solvent" in autonomic response testing.) See chapter 10 of my book at <http://www.neuraltherapybook.com>.

A response to the presence of DMSO indicates that the body "sees" DMSO or some other organic solvent to be a threat, past or present. It could mean that the patient had a toxic exposure or allergic reaction in the past, or is currently (at the time of examination) reacting to an organic solvent. Because the reaction to the presence of DMSO was only at the wrist, and not over the liver or the umbilicus, it was likely that the threat was local, i.e. where the interference field was found. However, the interference field also reacted to the presence of procaine. This meant that neural therapy was indicated. The interference field was therefore treated with the Tenscam device. (Quaddles of procaine would have been equally effective.)



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No skin lesions were present at the time of treatment, so the effect on the patient's skin reactivity could only be gauged with the passage of time. At a return visit 9 weeks later, he had had only one small "breakout" 3 weeks before and no interference field was present at the wrist. However at 5 months a generalized "breakout" occurred, while under a period of personal stress. The interference field at the wrist reappeared and was treated as before. A month later, the skin was much improved, but a small area of rash persisted on the wrist.

This time the right upper arm was checked (for the first time) and an interference field was found at the location where the fake tattoo had caused so much trouble 6 years before. It also reacted to the presence of DMSO. Now the whole case was making sense!

The fake tattoo was of a henna type which I learned (after some research) often contains phenylenediamine, an organic solvent with allergenic potential. This was the "tissue memory" that played out when the skin in the arm was injured by a second trauma ("the second blow" of Speransky). Although the second injury was blunt trauma and had nothing to do with organic solvents, the tissue memory can be triggered by any sort of trauma, anywhere in the body.

This pattern is identical to that elicited in the famous tetanus and rabies experiments of Speransky in the 1930s where the pattern of a past infectious disease could be provoked by stimulating the nervous system at any point with a non-infectious irritant.

Speransky's theory (yet to be disproved!) was that all illness is under the control of the nervous system. This case demonstrates that this holds true for the skin as much as any other organ system.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of Neural Therapy: Applied Neurophysiology and Other Topics

Dear Colleagues:

A few months ago I briefly discussed an energetic (as opposed to a neurophysiological) model of interference fields. (See July 2011 e-newsletter at mail to: <http://www.neuraltherapybook.com/newsletters/>.) The energetic model is best understood as a focus of "anticoherence" in the body's energy field; the neurophysiological model can be described as a focus of electrophysiological instability, particularly of the cell membrane. Each model has its pros and cons; no doubt there is a place for combining both.

This month I would like to report a case that demonstrates the value of the energetic model of interference fields. It is not a rare example; experienced neural therapists identify such things commonly.

An otherwise healthy, energetic, unmarried 37-year old woman presented with 16 years of intractable diarrhea. She was having three or four bowel movements a day without blood or mucus.

She had lived in Thailand, Nepal, Malaysia and Korea in her early twenties around the time her symptoms began. Intestinal parasites had been diagnosed and treated, but the symptoms continued. Eventually Crohn's disease was diagnosed; the diagnosis was made easier by Crohn's disease being common in her family.

Medical treatment of the Crohn's disease and dietary modification had been ineffective and eventually (6 months before presenting at my office) she had a partial small and large bowel colectomy - including the ileocecal valve. For one week, after the surgery, her bowel movements completely normalized! She was naturally delighted but this short-lived relief turned to dismay as the diarrhea returned, with even more watery stools.

However, this short period of remission did have the benefit of sustaining her hope that a cure could yet be found. Her research on the internet finally directed her to my office.

In addition to the history mentioned above, she had no trauma or medical procedures other than surgery at age 19 to correct a ureteral deformity near her right kidney. She experienced occipital headaches two or three times a week beginning in her twenties, as well as dysmenorrhea from age 25.

Her general examination was unremarkable except for anterior rotation of her right innominate combined with slight tension in her right hamstrings, relative to the left side. "Arcing" (a subtle pulsation emanating from a specific locus at about 60 cycles per minute) could be felt from the pelvis and the kapha pulses were weak bilaterally (See the February 2011 e-newsletter at mail to: <http://www.neuraltherapybook.com/newsletters/>.) Both these findings indicated an energetic disturbance in the pelvis or lower abdominal region.



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For neural therapy and advanced healing*



Autonomic response testing indicated an interference field in the ileocecal region (even though the ileocecal valve and surrounding large and small bowel had been removed). The interference field was treated using a Tenscam device. (Quaddles of dilute procaine into the skin overlying the interference field would likely have had the same effect.)

One month later the patient returned to report that her stools had completely normalized (almost immediately) and that her headaches were less frequent. No further treatment was required and the patient was discharged, with advice to return only if she should have a relapse.

Interference fields in organs or tissues that have been surgically removed are particularly good instances of disturbances of the body's energy field that are hard to explain with the neurophysiological model. Post-cholecystectomy syndrome symptoms occur in up to 40% of operated cases and although sometimes caused by an interference field in a surgical scar, the interference field is often found in the (removed) gall bladder. It is as if surgery removes the physical structure, but the energetic structure remains behind.

Clinical evidence for the concept of the "energetic" vs the "physical" body rests on energetic diagnostic techniques such as autonomic response testing and the sensory skills of some manual therapists. Energetic therapeutic devices such as the Tenscam and lasers support this further by their effects, especially in neural therapy. Experimental work such as Becker's amputation and re-growth of salamanders' limbs provides further corroboration of this concept by demonstrating the existence of an energetic "map" determining the body's structure and shape (Becker RO, Selden G, 1985, *The Body Electric*, William Morrow & Co. New York).

This energetic model of interference fields cannot replace the classical neurophysiological model, but like all new scientific models, it provides explanations for otherwise inexplicable phenomena and prepares our minds for the possibility of further advances in neural therapy and in medicine.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of Neural Therapy: Applied Neurophysiology and Other Topics

Dear Colleagues:

The interface between neural therapy and autoimmune disease is a complicated one. The etiology of autoimmune diseases is poorly understood to begin with, and what role the nervous system has in initiation and propagation of these conditions is unclear. Yet a connection does exist.

Dosch in his textbook "Manual of neural therapy according to Huneke" reports a few case histories of autoimmune disease cured by injecting interference fields. One was a case of psoriasis cured by injecting an eyebrow scar (p.227 of the 2005 edition). Another is of a "rheumatic" arthritis of a knee, treated successfully by injecting an eye tooth. (p.99).

I have had similar experiences, treating polymyalgia rheumatica, rheumatoid arthritis, and most recently psoriasis. All have been related to dental infections. The cases of polymyalgia rheumatica were the most successful, and always required thorough (and sometimes extensive) dental treatment of visible and occult dental infections.

Rheumatoid arthritis is in my experience much more difficult to treat. The only cases with which I have had success have been milder or intermittent ones or those treated near the onset of the disease process. In each case, the dental interference field has resonated (from autonomic response testing) with a dental infection homeopathic or a Sanum isopathic. Treatment involves injecting with procaine and the appropriate homeopathic, or Tenscam treatment through the homeopathic. Dental neural therapy treatments usually require one or two treatments a week for up to three weeks.

I have seen patients with psoriasis over the years, but usually only as a co-morbidity of a more pressing problem. Recently I was referred a woman with quite severe psoriasis by a biological dentist who astutely noticed that the patient's psoriasis began soon after treatment of a dental infection. This case is ongoing, but enough has already occurred that I want to share this story:

A 40-year old woman presented with severe generalized psoriasis sparing only her hands and feet. The onset of the disease had been preceded by infection of a tooth that had been surgically treated for periapical cemental dysplasia. Several courses of antibiotics had been prescribed.

She had a past history of irritable bowel syndrome and her bowel movements had again become loose with the onset of the psoriasis. Other past history included frequent ear infections as a child, removal of a cyst in the rectal area at age 7, injury to an upper incisor at age 12 and a root canal procedure at age 16.

The patient, aware of the relationships between irritable bowel syndrome, autoimmune diseases and gluten sensitivity, eliminated gluten from her diet for two months - again with no response in her skin or bowel. The referring dentist



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For neural therapy and advanced healing*



extracted the root canalled tooth (1.1) in the hope of attenuating the psoriasis but no response was obtained even though the tooth proved to be infected.

*On examination a slightly inflamed papular lesion, about 2mm in diameter was present on the lingual aspect of the mucosa adjacent to tooth 2.1. No interference field could be detected on autonomic response testing, but an interference field was found in the left spheno-palatine ganglion. The autonomic response reversed with the presence of two dental homeopathics: *staphylococcus aureus* and *wurzelbehandelter zahn*.*

Neural therapy of the spheno-palatine ganglion resulted in a marked improvement of the generalized psoriasis within days. 11 days later it was "60% better". The method of treatment was not the classical procaine injection but rather a 1-minute "Lasercam" treatment. This device, (designed by Charles Crosby DO, the inventor of the Tenscam) includes a laser function emitting a pulsed 470 nm wavelength (in the blue light range). I will discuss the presumed mechanism of action and why I chose this method of treatment in a future newsletter.

These physical findings indicated that the sphenopalatine ganglion had been enlisted by the body to help defend itself from a dental infection. (See Newsletter Volume 4, No.10 in <http://www.neuraltherapybook.com/newsletters/>). The ganglion "knew" what the infection was (as evidenced by autonomic response testing), but was overwhelmed and became itself an interference field. Interference fields, when intense enough, can create problems anywhere in the body. In this case, the patient's genetic predisposition allowed this to be expressed in the skin as psoriasis.

This patient had a very strong family history of diseases associated with gluten sensitivity, was in remission from irritable bowel syndrome and was herself suffering from psoriasis, an autoimmune disease. (The risk of autoimmune disease increases 10-fold for the gluten-sensitive who continue to consume gluten.) The autoimmune process seems to involve induction of anti-tissue transglutaminase antibodies in the gut mucosa by gluten. Recent research shows that a variety of these antibodies exist, each specific to a certain type of tissue. This helps explain why gluten sensitivity manifests as a gastro-intestinal disease in some, as neurological disease in others, as skin disease in yet others, etc.

There is also (as mentioned above) a connection between dental infections and at least some of the autoimmune diseases. It would seem that this patient was caught in a "perfect storm" of gluten sensitivity, irritable bowel, a chronic infection, and an interference field in the most energetically sensitive part of the body, namely the mouth.

The remaining unanswered question is: How does the nervous system fit into all this? I believe the answer can be found in the challenge issued by Speransky in 1935 by his book: *A Basis for the Theory of Medicine*. More about this in a future newsletter!



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of Neural Therapy: Applied Neurophysiology and Other Topics

Dear Colleague:

Last month I wrote a preliminary report on a woman whose severe psoriasis responded dramatically to one neural therapy treatment of a sphenopalatine ganglion. <http://www.neuraltherapybook.com/newsletters/>. She continues to do well. However the neural therapy was not the classical (according to Huneke) injection of procaine. Rather I chose to use a new technology, a device called a "Lasercam" - a variant of the Tenscam (about which I have written a number of times). And I promised to explain.

The "new" feature of the Lasercam is a pulsed laser energy in the 470 nm range. This frequency has been shown to destroy methicillin resistant staphylococcus aureus and pseudomonas aeruginosa in vitro: [Blue 470-nm light kills methicillin-resistant Staphylococcus aureus \(MRSA\) in vitro](#). The use of this form of laser technology is in its infancy and possibly other organisms respond to this frequency as well.

The reason I chose to use the blue light frequency rather than a classical procaine injection (or a regular Tenscam treatment) has to do with experience from another on-going case involving autoimmune disease. This patient has rheumatoid arthritis, a condition that (as I mentioned before) is hard to affect with neural therapy. Here is his story:

A 29 year old engineer presented a year ago with rheumatoid arthritis affecting his major joints including his right temporomandibular joint. This had begun gradually a year previously and was becoming increasingly severe and disabling.

It was noted that his symptoms had begun a month after a "flu shot", and in fact an interference field was detected (using autonomic response testing) in his left lateral upper arm, corresponding to the injection site. The autonomic response reversed with the presence of homeopathic "silberamalgam", an indication (in my experience) of a reaction to the thimerosal preservative present in many vaccines.

Six weeks later, the patient reported no change in symptoms, but on this visit an interference field was detected in tooth space 4.8 (32 in the American system). This could be reversed by the presence of homeopathic thioether and mercaptanum (homeopathics that often relate to dental infections).

Tenscam treatment through a vial of homeopathic thioether resulted in a few days of much reduced pain and swelling of the joints. On further visits, similar responses were obtained after finding and treating interference fields in the same tooth space, the submandibular ganglion, the left lateral arm, the stomach and the anus. However response to treatment became less with time and the 4.8 tooth space interference field kept returning.

The patient was then sent to a biological dentist for surgical debridement of the tooth space. Unfortunately this had no effect on the progress of his disease. After



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For neural therapy and advanced healing*



four months of neural therapy, dietary changes and nutritional support, no progress was being made and the patient was referred to a very experienced and skilled constitutional homeopath. Various remedies were tried over the following 3 months, but his condition continued to deteriorate. The patient finally agreed to the recommendations of his rheumatologist and began to take prednisone and methotrexate.

The patient responded to medication with considerably less pain and improved mobility. Two months later the doses were stabilized and on re-examination, tooth space 4.8 again responded to autonomic response testing, with a reversal from a dental homeopathic. This time I decided to try the Lasercam, the rationale being that the 470 nm light frequency might destroy bacteria that might be triggering the rheumatoid process. The response was dramatic; the patient felt immediate tingling and warmth over the jaw and cheek and then marked improvement in joint pain and mobility for five days.

Repeat treatments were increasingly effective. After a few weeks, he was able to reduce his prednisone and was able to undertake strenuous physical exercise landscaping his new home. Three months later, he continues to reduce his medication and is maintaining a virtually pain-free state.

I am reporting these two cases of autoimmune diseases responding to treatment of interference fields by a specific laser frequency for two reasons: (1) the therapeutic potential of specific laser frequencies on interference fields, and (2) the theoretical implications of treating interference fields with energetic "information", rather than simply with procaine (or a non-specific scalar energy).

The goal of classical neural therapy (according to Huneke) is to erase the electrophysiological disturbance of an interference field. The goal of a more specific energy-based neural therapy is to eliminate not only the interference field but the information that it contains. We know that this is possible with emotionally laden interference fields (See chapter 11 of my book <http://www.neuraltherapybook.com>). We have seen further evidence of this by combining homeopathics with procaine in treating certain conditions, e.g. dental infections. These two cases suggest that systemic disease processes emanating from the information found in interference fields have potential for successful treatment in this way.

Space does not allow more discussion of these theoretical implications - perhaps more in next month's newsletter!



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NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleague:

In the last two [newsletters](#), I described two cases of autoimmune disease that have responded to a new form of energetic neural therapy - a pulsed laser energy designed to treat certain bacterial infections. In both cases clear-cut remissions of autoimmune disease were achieved by targeting foci of bacterial infection - present or past.

The idea that infections can trigger autoimmune disease and (more specifically) rheumatoid arthritis (RA) is an old one. Researchers have for over 100 years tried to link various bacteria, fungi and yeast with RA. In the early part of the 20th century Weston Price (and colleagues) performed animal experiments demonstrating the causal relationship between dental infection and autoimmune diseases. This theory (focal infection theory) fell out of fashion, but in more recent years, [minocycline](#) and anti-malarials have been reported to be effective in treating RA. I have had a few cases of early or relatively mild RA that were cured by neural therapy of infected teeth and/or dental extraction combined with careful curettage.

However the two recent cases that I reported have been different. Both were quite severe. Both had been triggered by traumas about a month before the onset of symptoms - the first (psoriasis) by a dental infection and surgery, the second (RA) by a vaccination. The response to treatment, though not "lightning reactions", were rapid and profound.

So how does an interference field produce a systemic disease? To understand this, we need to return to the experimental work of Speransky, described in his monumental book "A Basis for the Theory of Medicine" in 1935. (This book has long been out of print, but a few used copies are still available on the internet -at \$500 US and up!)

Speransky's thesis was that the nervous system controls the evolution of systemic disease. Perhaps his most intriguing experiment was to inject a sub-lethal dose of tetanus toxin into a hind leg of a dog. The dog developed local signs of tetanus, but recovered normal health and complete function after a few weeks. Then many months later, the nervous system of the dog was irritated in a variety of ways: by section of a major nerve or tooth with application of a toxic chemical, or implantation of a small glass ball into the brain. The result was tetanus, beginning in the hind leg and progressing to involve the whole animal and ending in death! Similar results were obtained using other pathogens, including rabies.

The implication of this experiment is that knowledge of the disease (in modern computer language "the program") is stored in the nervous system and can be recalled by a sufficient irritation anywhere in the body. It is not necessary for the pathogen that provoked the initial reaction to be present!



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For neural therapy and advanced healing



In neural therapy we commonly see "programs" of pain, visceral disturbances, etc. associated with interference fields. Compared to the clinical manifestations of systemic infections or autoimmune diseases, these programs are simple. The idea that interference fields can harbor the information that plays out as a systemic disease is much more complex, but based on Speransky's work, is possible. Similar phenomena occur in homeopathy and are of the same order of magnitude.

What is interesting about the response to treatment in these two cases is that the treatment targeted very specific bacterial agents (or their energetic information) that are suspected to trigger autoimmune diseases. Moreover, the response was much stronger than that obtained by non-specific neural therapy, even when combined with a homeopathic.

These two reports are preliminary and their eventual outcomes remain to be seen. Speransky warned that disease processes once established have a life of their own. However the point at which the process "escapes" is different in every case and is impossible to know in advance. Interference fields should therefore be searched for in all cases and an attempt made to treat them when found.

Speransky was very aware of the potential of procaine to influence "dystrophic processes", (as he called the neurogenic pathophysiology that he described). He used procaine in research and also therapeutically. His treatment of acute pneumonia was identical to that which neural therapists call "[segmental therapy](#)". However (at least from what I can glean from his book), he never stumbled across the phenomenon of the interference field.

It would be interesting to repeat the classical Speransky experiment described above, to look for an interference field at the point of the initial injury and to treat the interference field with procaine alone, or with procaine and an appropriate homeopathic, or with an energetic device such as the Lasercam.

The experiments described by Speransky raise as many questions as they answer. His work (even though 75 years old!) is still a challenge to the medical profession to rethink its theory of medicine. Perhaps by blending our knowledge derived from Speransky's experiments with classical homeopathy and a modern understanding of energetics, we will be in a better position of make sense of the many diseases of modern medicine still lacking explanations.

Dosch's Manual of Neural Therapy has a [summary of Speransky's work](#) as it applies to neural therapy. A short biography and some observations about his work can also be found in [Poldovsky's book](#), "Red miracle - The story of Soviet medicine".



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

When is a hip pain not a hip pain? The answer is: when the pain is coming from somewhere else.

Hip pain is not alone in this regard. Chronic pain often surfaces in locations far from its origin. However pain felt in the hip is (in my opinion) one of the more poorly diagnosed.

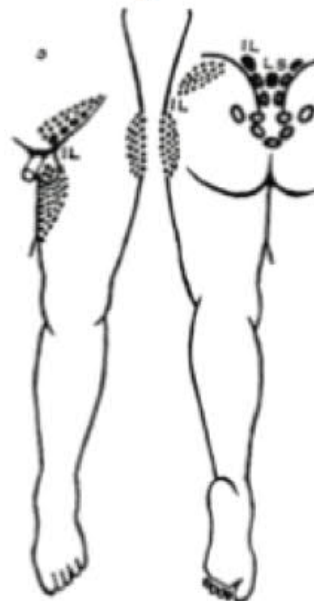
Most physicians are aware that hip pain is unlikely to be caused by problems in the hip itself. For example the pain of hip osteoarthritis is generally diffuse, radiates down the anterior aspect of the thigh and is much affected by hip movement. Pain from the piriformis muscle (See [newsletter Vol 1, No. 3](#)) is felt behind the hip and in the low back, although it too may radiate down the leg.

Other hip problems are reflected in disturbed hip mechanics, which are identified when testing the hip's range of movement: flexion, extension, ad/ab-duction, and rotation. When no mechanical disturbance is found and particularly when there is tenderness over the greater trochanter, the diagnosis often becomes (by default) "trochanteric bursitis".

Fortunately the term "trochanteric bursitis" is finally falling out of fashion. Evidence is accumulating that no bursitis exists in most of these cases. The new term to describe pain over the hip, associated with tenderness, and often relating to overuse, leg length discrepancy, etc. is "greater trochanteric pain syndrome (GTPS)".

This is a welcome change. In my opinion, the suffix "-itis" is attached to too many structures when the only physical finding is tenderness. Tenderness can be referred, just as is pain. Hackett demonstrated that hip pain may be referred from a trigger point in an irritable iliolumbar ligament. Of course iliolumbar pain may also refer to the groin, testicle and proximal medial thigh.

Referred Pain - Iliolumbar Ligament





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Janet Travell discovered similar referral patterns to the hip from trigger points in the quadratus lumborum muscle:

Hip pain from these sources can be treated by injecting procaine directly into the trigger points or by segmental therapy (quaddles of dilute procaine over the affected ligament or muscle). However lasting relief requires that the causes of the trigger points be addressed as well e.g. addressing somatic dysfunction in the pelvic ring, the legs, the lumbar spine or even remote areas of the body.

Another less common (but important to its owner) source of hip pain is referral from an interference field in a low thoracic paravertebral sympathetic ganglion. These usually occur in more complicated cases where neurological signals are contributed from interference fields in other associated tissues or organs. Here is a case example:

An 80 year old woman complained of hip pain since a fall on her side about 2 months before. Somatic dysfunction of the pelvic ring was identified and treated using osteopathic-type manipulation. However on follow-up a few weeks later the patient reported no change in her pain. This time she was accompanied by her son who corrected his mother's history, stating that she had fallen 6 months previously and that she actually had some pain even before that. In fact she had "not been right" since a gynecological operation that had been complicated by infection and a long convalescence several years before.

No interference field could be detected in the surgical scar or pelvis, but an interference field was found by autonomic response testing at the left T10 sympathetic ganglion. It was treated with a Tenscam device with satisfactory resolution of her pain within days. (The classical neural therapy treatment would have been injection of the ganglion with 10cc of dilute procaine. See page 186 of my book for details of technique.)

The new descriptor of localized hip pain "greater trochanteric pain syndrome" is an improvement over the older (and misleading) term "trochanteric bursitis". However it gives little help in understanding etiology. Understanding the structures that refer pain to the hip is the key to successful treatment.

A free Spanish language neural therapy newsletter is available, published by Dr. David Vinjes of Barcelona, Spain at <http://www.terapianeural.com/>. Sign up at the site!

Discussions are underway with regard to translating both English and Spanish literature. Feedback with regard to interest is invited from you, the readership of this newsletter.

5th World Biennial Congress of Neural Therapy in Quito, Ecuador from March 15th to 18th, 2012: <http://www.neuraltherapybiennial.com/>.

Several North Americans (including I) will be speaking and attending for the first time. Consider joining us. The Spanish, the German and the English speaking worlds of neural therapy have much to learn from each other!



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NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

This month I would like to discuss sequestration of toxic metals (usually mercury) and what this means in the practice of neural therapy. The word sequestration means in chemistry the binding of a chemical element or compound so that it is no longer available for reactions. In pathophysiology, it means binding of an element or compound in a particular location in the body.

It has been known for a long time that toxic substances when introduced to the body do not distribute evenly. Certain organs are more commonly targeted, the kidneys for example. The kidneys therefore "sequester" mercury. However this does not mean that they are more adversely affected than other organs. In fact, the kidneys seem to resist poisoning relatively well. Kidney failure by chronic mercury poisoning is probably rare. (Although I sometimes wonder about the many cases of kidney failure of "unknown cause").

Chemicals deposit in specific areas according to the chemical environment in the area. If a dissolved substance precipitates because of lower pH in a test tube, it will do the same thing in a body tissue. It stands to reason that tissues that are not healthy are therefore more likely to accumulate toxins, especially toxic metals. This becomes a vicious cycle, because the presence of the toxic element worsens the condition of its environment.

Interference fields are by definition areas of disturbed physiology; included in this definition is disturbed chemistry. It should not therefore be a surprise that toxic chemicals can accumulate in interference fields. This has clinical implications.

Experienced neural therapists are aware that neural therapy of an interference field, "opens up" the circulation of the area and helps release toxins. This can be beneficial, as when toxins that have accumulated in the liver (causing an interference field) are released, and liver function improves. Or it can be detrimental, when neural therapy of a tissue containing mercury "opens up" the tissues and releases mercury more quickly than the excretory organs can handle it.

The following case report is an example of the second scenario:

A 51 year old single business woman complained of several years of fatigue. A diagnosis of chronic mercury poisoning was made; her dental amalgam was replaced with composite material and she underwent a detoxification program, including intravenous DMPS chelation. The response to chelation was monitored by regular urinalysis for toxic metals and the chelation was continued to the point that her energy was restored and her urinary excretion of mercury was minimal.

Active treatment was discontinued, but two months later she underwent minor elective oral surgery. She suddenly became fatigued and in fact stated that she felt "exactly as before" her amalgam removal and detoxification. Intravenous DMPS was again administered and a very high mercury level (over 175 micrograms/gm. of



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creatinine) was measured in the urine in the first 6 hours. Repeat intravenous DMPS injections reduced her mercury excretion to normal and restored her energy level over the ensuing months.

Similar responses may occur with neural therapy of cranial autonomic ganglia, especially the sphenopalatines. Research has shown considerable accumulation of mercury in the soft tissues and bones of the lower face in those with dental amalgam (past or present). Neural therapy of the sphenopalatine ganglion can in certain patients provoke a significant toxic reaction.

Sequestration of mercury (and other toxins) has practical clinical importance. However it also raises theoretical problems for scientific measurement of toxic "body burden". Attempts have been made to assess the total amount of toxic metals in the body using chelating agents in provocation tests. The Quicksilver Tri-test (See "[Quicksilver](#)" vol.5, no.5 newsletter) attempts the same thing with mercury. However no method to date takes into account the possibility of sequestration of metals.

Both diagnosis and assessment of the response to treatment of chronic metal toxicity must continue to be matters of clinical judgement. Laboratory tests can be helpful, but sequestration of toxic metals continues to be a confounding factor of which clinicians need to be aware.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of Neural Therapy: Applied Neurophysiology and Other Topics

Dear Colleagues:

This month's newsletter is a report on the World Conference of Neural Therapy, which I recently attended in Quito, Ecuador. This is a biannual event, always held in Ecuador, but attracting physicians practicing neural therapy from all over Central and South America, Europe and (this time) North America.

My reason for attending was to learn more about how neural therapy is practiced in Latin America, and (to a certain extent) Europe. Language has been a barrier for those of us who do not speak Spanish and German, and this conference, which offered simultaneous translation, seemed a good place to start.

My curiosity was certainly satisfied. The conference opened in style, with greeters in colourful traditional Ecuadorean dress, traditional Andean music, a phalanx of national flags behind the head table, singing of the national anthem, etc. Ecuador, and Quito in particular, is attempting to position itself as a world center for neural therapy. City council has been persuaded to name a street after the Huneke brothers, and funds are being raised to erect a statue in their honor. To give an idea of how big neural therapy is in Ecuador, the city of Guayaquil has 150 physicians who practice it.

The program featured speakers from Mexico, Costa Rica, Ecuador, Chile, Argentina, Germany, Switzerland, USA and Canada. A wide range of contemporary neural therapy was represented. At one end of the spectrum the classic teachings of the Huneke brothers were passionately defended. At the other end, the most recent advances using scalar and laser energies were introduced. In between were lectures showing how neural therapy can be combined with acupuncture, nutrition, homotoxicology and homeopathy.

Case history was a favourite method of teaching, with many before-and-after videos of severely incapacitated patients responding dramatically to neural therapy. These were reminders that even the most severe neurological cases should be examined carefully for interference fields, especially in the head and neck.

The organization is called World Academy of Neural Therapy according to Huneke and Neurofocal Dentistry and the importance of dentistry was not neglected. Lectures on dentistry and dental radiology were given, and the importance of understanding dental pathology worked itself into almost every lecture.

Now for some "pearls":

- Varicose veins respond to neural therapy and should be treated if only to prevent pulmonary emboli. 30,000 people die in Germany every year from pulmonary emboli. On the other hand, deep vein thrombosis should be handled with great care, as precipitation of emboli by neural therapy is a



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- risk.
- Neural therapy can reduce the "peaks" of pain in diabetic neuropathy.
 - "Whiplash" injuries increase the risk of developing fibromyalgia by 10 times. Stellate ganglion interference fields are often found and should be treated.
 - Fibromyalgia is often associated with chronic pelvic infections and may respond to neural therapy.
 - Chronic pain results from an imbalance of the two main functions of the nervous system: maintenance of tone and trophism. Neural therapy facilitates recuperation of both.

The conference did not limit itself to neural therapy. Lectures were given on topics likely to be of interest to physicians practicing somewhat outside the mainstream: for example, intravenous vitamin C in detoxification, PRP (platelet rich plasma) injections, gluten sensitivity and micronutrient treatment of cancer.

As in all good conferences, some of the most valuable time was spent in discussion between lectures, during coffee breaks and at meal times. A shared passion for neural therapy and a spirit of camaraderie transcending language and culture was very much evident. The next conference will be in two years, tentatively on the Galapagos Islands.

An English edition of AD Speransky's *A basis for the theory of medicine* is back in print! Copies can be purchased for \$20 US (plus shipping) as follows:

1. email service@intpubnyc.com
2. fax to 212-366-9820
3. phone 212-366-9816
4. postal mail to International Publishers Co., 235 W 23 St., New York, NY 10011, USA.



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Volume 7, No. 5, May 2012

NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

You may have noticed in last month's newsletter notice of re-publication of Speransky's seminal book: *Basis of the theory of medicine*. There is a story to tell about this republication, or at least of my discovery of it.

As readers of this newsletter know, the name of Speransky comes up frequently when discussing neural therapy. I am not alone in my indebtedness to Speransky's ideas. Dosch's textbook *Manual of neural therapy according to Huneke* devotes 2 ½ pages to him. In my opinion, Speransky's book is required reading for anyone who is seriously interested in the mechanisms lying behind interference fields and how they translate into the pathophysiology we encounter every day in our practices.

This is so, even though Speransky's work predates (by almost a decade) Ferdinand Huneke's epochal discovery of the interference field in 1940. Speransky's contribution was not to the practice of neural therapy itself, but rather to understanding how these little interference fields can create such big and complicated problems.

The Speransky book was last published in 1943, and used copies in English have become harder and harder to find. I was thinking about this when discussing book publication with an Argentinian physician, Dr. Pablo Koval, who spoke at the recent World conference on neural therapy in Quito, Ecuador. He has recently published a book on neural therapy in Spanish: <http://www.libro-terapianeural.com.ar/compra.html>.

Dr. Koval, who is an anesthetist, chronic pain specialist and experienced neural therapist, spoke on chronic pain (he prefers the term "persistent pain"), as being due to an imbalance of tonic and trophic neural processes. These ideas draw straight from Speransky and very much complement modern theories of "neurogenic inflammation". I am hoping that Dr. Koval will have his book translated into English. If you would like to encourage him to do so, his email address is drpablokoval@gmail.com.

Our common interest in Speransky and publishing (and a nudge from a Canadian colleague who was also at the conference), lead me to the idea of perhaps republishing Speransky's book. Speransky died in 1961, and copyright laws allow books to fall into the public domain 50 years after the death of the author (unless claimed by the estate). Discussion of this possibility with my local publisher prompted some research into the book's status, and to my surprise the rights to the book were still in the hands of the original publisher, an obscure New York company called "International Publishers".

An even greater surprise was that the publisher had recently reprinted the book at the request of a group of chiropractors and that books are now available for



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sale!

The story becomes even more interesting! My own ancient copy has a tattered flyleaf advertising other books by International Publishers: one is "Dialectics of Nature" by Frederick Engels. Included is a preface by JBS Haldane, a noted scientist and doctrinaire Marxist of the time. A look at [International Publisher's website](#) reveals that it is a publishing arm of the Communist Party of the USA! It features books by Marx, Engels and Lenin and states that "we enjoy providing the finest working-class literature available at the best prices".

There is a certain irony in this. After the Second World War, there was a movement in the Soviet Union, to require that scientific research be conducted in line with Marxist-Leninist theory. In 1950 a joint session of the USSR Academy of Sciences and the USSR Academy of Medical Sciences held what was to be called the [Pavlovian Session](#) in which scientists who were not deemed faithful to the political orthodoxy of the time were accused and relieved of their posts. Speransky, who was head of Institute of General and Experimental Pathology was among these. According to the Wikipedia writer - "As the result of this session, Soviet physiology self-excluded itself from the international scientific community for many years."

What a bittersweet paradox that 60 years later, Speransky's work should still be read and respected and the political system that rejected him is now "in the dustbin of history". And that Speransky's book should be published by followers of the same people who condemned him so long ago.

The American Communist Party is not likely to get rich on selling Speransky's book at \$20.00/copy. So that shouldn't stop you from ordering this important book: <http://www.intpubnyc.com/>.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

A recent case in my office has prompted me to tackle a complex subject: neural therapy's place in treating sexual dysfunction. A short newsletter does not allow for discussion in depth, but a few observations and a case history may be helpful nevertheless.

Sexual dysfunction receives only cursory coverage in the Dosch neural therapy textbook. Perhaps that reflects the era in which it was written. Sexual function has become a preoccupation of our time, (for better or for worse) and physicians are now expected to have at least some knowledge of it.

Sexual dysfunction (in its broadest sense) may be classified in three categories, although there is often considerable overlap. The first group has an emotional basis, e.g. relationship difficulties, unresolved emotional conflicts, a history of sexual abuse, anxiety, or simply preoccupation with other life matters. The research literature provides abundant evidence of the psychosomatic basis of much sexual dysfunction. The evidence can be summarized by concluding that nature has a way of suppressing sexual interest (and function) when there are more important issues at hand, such as survival.

The second category of sexual dysfunction is related to hormonal deficiency, especially (but not exclusively) the sex hormones. Here overlap with the previous category is possible, as a high stress lifestyle may provoke the so-called "cortisol steal", where the adrenal glands produce more cortisol at the expense of the sex hormones. Treatment of sexual dysfunction involving hormonal issues nearly always requires concurrent attention to lifestyle and nutritional status.

The third category of sexual dysfunction is that involving neurophysiological problems. It goes without saying that brain and spinal cord injury, adverse drug reactions, diabetic neuropathy and other neurological conditions can cause sexual dysfunction, usually difficult to treat. However there is a subgroup of patients whose sexual dysfunction is related to autonomic nervous system disturbance, who are candidates for neural therapy.

These patients often have suffered trauma to the reproductive organs or pelvis. Childbirth and gynecological surgery is the most common in women, prostate surgery the most common in men. Both sexes can also be affected by external trauma, such as motor vehicle accidents.

The most common interference field affecting sexual dysfunction is the pelvic plexus (or "Frankenhauser plexus"). It is not unusual for patients to report improved sexual function after treatment of the pelvic plexus, even when the goal is to treat some other problem, such as chronic pain or menorrhagia.

A rare (in my experience) interference field affecting sexual function is a vasectomy scar. Here is a recent case from my practice:



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For neural therapy and advanced healing



A healthy 59-year-old man presented with bilateral anterior knee pain of gradual onset and of 5 years' duration. He had had x-rays, physiotherapy and an exercise program with minimal improvement. While giving his history, he volunteered that he had suffered from intermittent erectile dysfunction for about 30 years. He had been investigated at a Men's Clinic and was told that his ED was "age and stress-related". He was otherwise in excellent health, was happily married, took no other medications and did not smoke. Cialis (tadalafil) was effective and helpful.

His surgical history was limited to wisdom teeth extractions in his youth, a vasectomy at age 29 and nasal septoplasty at age 39. Physical examination revealed tight hamstrings and depressed craniosacral rhythm throughout the body. However the pelvis was symmetric and there was no imbalance of the hip ad-/abductors. Somatic dysfunction was found at C2, the nose, thoracic diaphragm and the right sacroiliac joint. These were treated with osteopathic unwinding techniques and considerable relaxation of the tight muscles resulted. Autonomic response testing found an interference field in the right proximal scrotum, corresponding to a vasectomy scar. This was treated with a Tenscam device.

5 weeks later the patient returned with almost complete resolution of this knee pain, but what pleased him (and his wife) most was that the erectile dysfunction had disappeared. In fact he was experiencing morning erections for the first time in over 30 years.

The relationship between vasectomy, sexual function, post-surgical pain and prostate problems including cancer has been studied for over 30 years. Post-vasectomy pain syndrome is not rare and is a recognized entity. Erectile dysfunction may occur after vasectomy but when this occurs [psychosocial factors are considered to be the most likely cause](#). In fact after many years of research, prevailing opinion now appears to be that the surgical procedure itself offers [no significant risk of sexual dysfunction](#).

Erectile dysfunction caused by vasectomy scar interference fields must therefore be rare, or at least uncommon enough that the incidence is masked by the more readily identified psychological factors. I would be interested to hear from readers if any others have come across vasectomy scar interference fields causing sexual dysfunction.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

Last month's newsletter was about sexual dysfunction and its relationship to interference fields. It included a case report of a man whose long-standing erectile dysfunction was cured by treating a vasectomy scar with neural therapy.

My guess was that vasectomy scars rarely cause problems of this sort and I asked readers (now over 1000 subscribers) to report if their experience was different. I generally receive a satisfying amount of feedback from readers about these newsletters, but not this time. No-one reported seeing this complication of vasectomy.

Dr. Robert Banner of Canada made this observation:

I have not come across vasectomy or circumcision scars as being interference fields and only once have I found an episiotomy scar to be an interference field. My thought for this was that they were rarely a problem because of the generally good blood supply there. It may be that I have not been as thorough in looking however. Sexual dysfunction is not one of the reasons someone would come to see me but this is very good to keep in mind as a possibility.

Dr. Margaret Taylor of Australia had this case to report:

I had a case of terrible pain and diarrhoea from a scrotal scar in a 15 year-old boy from an operation to remove a necrotic testis after a missed torsion of testis. The brave lad put up with 6 treatments until the pain went completely, as well as the diarrhoea. The first treatment only relieved it for 19 hours - but we figured that was enough to keep going. I had to treat the stump in the scrotum as well as the scar.

Dr Banner's observation that interference fields are rare in tissues with good blood supply matches my experience. Vasectomy scars also benefit from a second rule about interference fields: that elective surgery is much less likely to result in interference fields than emergency surgery, presumably because the decision for surgery is voluntary and less accompanied by anxiety or misgiving. (This may not be entirely true of vasectomy scars, [if the paper mentioned in the last newsletter](#) is significant).

Dr Taylor's case report supports this second principle in part. The patient's scar was in a well-vascularized location, but it likely contained the painful memory of the testicular torsion, the missed diagnosis and the subsequent surgery. It is interesting that treatment of the stump was also necessary. The stump would likely have also experienced some impaired circulation from the surgical procedure.

Pain may be a rare complication of vasectomy (probably <1 in 1000 vasectomized men), but vasectomies themselves are exceedingly common (4 million/year world-wide). As a result, "[post-vasectomy pain syndrome](#)" or PVPS is gaining increasing attention in the urological literature.

The pathophysiology of PVPS is controversial. Long standing obstruction of the spermatic duct, with extravasation of sperm and a resultant inflammatory response is the most widely accepted theory. Specific treatments are generally directed at reducing



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spermatogenesis (testosterone therapy), relieving pressure (vasectomy reversal), removing inflamed tissue (epididymectomy or orchiectomy) or denervation. All treatments have their failures and one wonders how many of these might be due to undetected interference fields. And even in those successfully treated, how many had pathology brought on by interference fields? In other words, why in some cases of vasectomy did the spermatic duct obstruction lead to extravasation and inflammation and not in others?

This situation is similar to another common post-surgical pain syndrome, the post-cholecystectomy pain syndrome. Although a variety of functional disturbances can be diagnosed to explain symptoms in some of these patients, many have post-surgical pain of "unknown" origin. Experienced neural therapists know that many of these are due to interference fields, in the cholecystectomy scar(s) or the "energetic" gall bladder itself. An [interesting paper](#) in the mainstream medical literature reports that at least some of these cases involve spinal cord sensitization. We can wonder if the autonomic nervous system plays any part in this sensitization.

Post-surgical pain syndromes are a risk in many types of surgery. It is high time that the basic principles of neural therapy be taught in all surgical training programs and that interference fields be sought for in all cases of chronic post-surgical pain.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

This month I plan to discuss the subject "safety in neural therapy". This is not a topic that comes up often in neural therapy discussions, perhaps because in comparison to most mainstream medical treatments, it is so much safer. I would guess that one of the great satisfactions for most physicians practicing neural therapy is seeing patients give up their anti-inflammatory medications, their anti-depressants, their anti-convulsants, etc.

However, neural therapy is considered an "alternative" treatment in most medical jurisdictions and because of this, (oddly enough) standards of safety must be much higher than for mainstream medicine. What makes this odd is that the medical regulatory authorities seem to be almost blind to the hazards of medicine to which they expect physicians to conform, yet portray "alternative" medicines as being dangerous.

Much of this attitude is fueled by ignorance and fear: ignorance of the practices that they proscribe, and fear that these alternatives might expose the inadequacies of the practices that they support. This situation has come to a head recently in the jurisdiction where I practice (Ontario, Canada). A new policy on Complementary Medicine is requiring physicians to spend much of their time warning patients of the risks of the services that they provide, and of course documenting everything.

This is annoying to both patients and the physicians they consult. It is also condescending. Patients generally consult physicians practicing outside the mainstream for their own reasons and in my experience they are already well informed - certainly better informed than many mainstream physicians.

Nevertheless raising the question of risks in "alternative" medicine has its value.

Risks, although few, do exist. This is true of neural therapy as with any other intervention in human physiology. However when researching the dangers of neural therapy, I could find nothing about risk in the peer-reviewed English literature. The *Manual of neural therapy according to Huneke* by Peter and Matthias Dosch (translated from German) appears to be the only resource for English readers. I particularly value the Doschs' writing on this topic, not only for their vast experience in neural therapy, but also for their contact with the great pioneers of neural therapy, including the Huneke brothers. If any complications of neural therapy occurred in those exploratory years, they would have heard about them.

The risks of neural therapy fall into two main categories:

1. Procaine (and other caine anaesthetics) allergy and toxicity.
2. Complications of injections into specific areas.

Knowledge of procaine toxicity comes from the anaesthesia literature. Anaesthetists use



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higher concentrations and larger doses than are generally used in neural therapy, so that if overdose reactions occur, anaesthetists are likely to be the first to encounter them. However dosage and concentrations are not the only factors to consider. The vascularity of the tissues injected and the period of time over which the injections are administered affect blood concentrations and the risk of reaching toxic levels. In classical neural therapy according to Huneke, many test injections may be given in one session, and attention needs to be paid to the cumulative amount being given.

Allergy to procaine is rare. Cases do occur, but I have never encountered one in my 24 years of neural therapy practice. The Dosch book discusses allergy in detail (pp. 277-79 in the most recent edition), giving advice on how to identify, to avoid and to treat allergic reactions.

Segmental therapy, scars and periodontal injections are virtually risk-free. However care needs to be taken with some of the deeper injections, especially those near arteries in the neck, the lungs and the spinal dura. Details of these are beyond the scope of this newsletter, but training should be obtained either from an experienced neural therapist or by consulting the Dosch manual when undertaking these injections.

Coagulation defects or anticoagulation therapy are not absolute contra-indications to neural therapy injections, but care must be taken especially when the INR is prolonged. Another circumstance involving clotting (or lack of it) is neural therapy treatment of varicose veins. This method, taught by German surgeon and neural therapist, Dr. Ulrike Aldag of Berlin, carries the small risk of dislodging venous thrombi and causing pulmonary embolism. However, with elementary precautions, this risk should be outweighed by the benefit of preventing pulmonary embolism, now the cause of death of 30,000 Germans per year.

Finally, a no-brainer: (I and my patient were caught by this many years ago.) Change your needle after injecting potentially infected tissue, like periodontal tissue. Using the same needle when injecting that small bolus of procaine intravenously can cause a septicemia. My patient developed pneumonia the day after I injected her infected tooth. No doubt it was the subsequent antecubital vein bolus using the same needle that caused it.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

I have been corresponding recently with an Austrian newsletter reader, Dr Johanna Osztovcics, who has kindly opened a window for me to the world of neural therapy in Europe. I was aware of course that neural therapy originated in Europe, and that it is widely practiced in the German and Spanish speaking countries. However the language barrier has prevented me from knowing much about its current status, short of the annual "Medizinische Woche" (medicine week) in Baden-Baden, which some North Americans attend.

The [Austrian neural therapy association](#) was founded in 1971. Their "congresses" are held every two years and have evolved from a small group of clinicians who knew each other well, to international meetings with lectures by anatomists and physiologists as well as clinicians. At their most recent meeting in 2011, a featured speaker was the French plastic surgeon and researcher [J.C. Gimberteau](#) who presented his marvelous [video recordings of the subcutaneous space](#). His book called "Strolling under the skin" outlines a new theory on "the concept of multimicrovacuoles to explain human intercorporeal organs sliding systems". Dr. Osztovcics observed that "though there are no immediate impacts on our NT-technique it changes the image we have in mind while sinking the needle".

The Austrian neural therapy association website has links with many other national societies including Belgium, Bulgaria, Columbia, Czech Republic, Germany (several societies), Greece, Italy, Mexico, Netherlands, Spain, Switzerland, and Turkey. (I was aware that neural therapy is being practiced in Turkey as this newsletter has several subscribers from there.) What a pity that there is not yet a single neural therapy association in the English speaking countries.

I was interested to learn about some of the topics currently preoccupying Austrian neural therapy leaders. They include questions such as "What are the core concepts of neural therapy?" and, "Are these principles being applied in too narrow or too wide a fashion?" In my opinion these are discussions well worth having, particularly among those teaching and writing about neural therapy. Educational programs must be designed, and the line between what is neural therapy and what is not, is not always clear.

I noticed this at the international conference on neural therapy in Quito last March. Some of the lectures were only very loosely linked to neural therapy, but were likely of interest to most attending because they appealed to inquiring minds. Because neural therapy is outside the standard conventional medical curriculum, only those physicians with a lively curiosity are likely to come across it and learn it.

I have to keep this in mind when writing this monthly newsletter. Often I come across something really interesting in my practice and would like to share it. However if it does not "fit", I have to discard it. My reasoning is that readers of this newsletter are searching for information about neural therapy - a rare commodity in the English speaking world.



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For neural therapy and advanced healing



So where does neural therapy fit in the world of medicine? It is certainly not a technique like Reike or reflexology that can be practiced independently of medicine. The Huneke brothers were mature physicians and their genius was to recognize the significance of what they had stumbled across, namely that focal disturbances in the body's regulatory mechanisms could be identified and treated. But as powerful an idea as this has proven to be, they knew full well that it was not a panacea. Already by the time Peter Dosch was writing his landmark Manual of Neural Therapy according to Huneke, neural therapy's limitations were being identified. (See pages 59 to 61 of the most recent edition.)

Pischinger (Vol. 3, No. 9, September 2008) took this further and showed that interference fields are intimately connected to the body's biochemistry and electrophysiology. My own contribution Neural Therapy: Applied Neurophysiology and Other Topics is an effort to apply some of these ideas in a practical way.

The pioneers of neural therapy recognized early an overlap with acupuncture and that acupuncture points are portals into the autonomic nervous system. I also have been teaching for many years that the osteopathic term "somatic dysfunction" is a musculoskeletal manifestation of an interference field and follows the same rules as do the better-known forms of interference fields.

The discovery by Klinghardt and Williams that applied kinesiology can be used to detect interference fields opened up energetic possibilities in neural therapy (at least for the English-speaking world. Similar discoveries were being made independently and perhaps earlier in South America by Payan and Duque.) Crosby's invention of the Tenscam made energetic treatment of interference fields possible, obviating the need for injections. And some practitioners have found that homeopathics can be combined with procaine or used in conjunction with the Tenscam to potentiate the results of classical neural therapy.

So we see that the core concepts of neural therapy are firmly embedded in the matrix of general medicine. And these also interconnect with some concepts that are not currently "mainstream". In practical terms this means that neural therapy works best when practiced by physicians who think broadly and deeply, and are skilled in many other aspects of medicine. More than a technique, it is a "way of thinking" that not only benefits the patient, but also provides profound intellectual satisfaction to those who practice it.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

This month I would like to discuss the problem of the "fussy baby". I use the term "fussy" because a spectrum exists between the newborn infant who simply fusses after being fed, to the full-blown, inconsolable, little screamer, who keeps the family up all night. These ones we identify as "infant(ile) colic" and some of these arrive at the Emergency Department during the middle of the night. I suspect that most physicians feel as helpless and upset as the poor parents.

Fortunately most cases of infant colic seem to settle spontaneously after three months of age. However they can be a hard three months for the parents, not to mention the baby, to endure. Some studies report that up to 30% of infants are affected.

Despite its prevalence, no consensus yet exists as to its etiology or pathogenesis. Theories on offer include food hypersensitivity/allergy, gut dysmotility, psychosocial factors, gut dysbiosis and genetic factors. One recent paper reported that infant colic is more common in children whose mothers have migraine. Another reports an association with helicobacter pylori in the infant.

Non-mainstream medicine has been more pro-active. Chiropractors sometimes offer spinal manipulation as treatment for infant colic. I have heard occasional good reports from patients about this treatment, but recent meta-analyses of randomized clinical trials found no evidence or weak evidence of its efficacy. Treatment of infant colic by cranial manipulation has long been offered by the osteopathic profession, though again little solid "evidence" is available to support its value. (In my opinion, manual therapies do not lend themselves to controlled studies and will therefore never be evidence based.) A section in the "foundations of Osteopathic Medicine" (p. 322 of the 2nd edition, 2003) describes the various lesions associated with infant colic and methods to treat them. The rationale of cranial manipulation in this situation is to correct irritation of the accessory, glossopharyngeal and/or vagus nerves.

The idea of manually "moulding" the cranium of new-borns is part of certain folk traditions e.g. Haiti and Pakistan. Presumably the purpose of moulding in these circumstances is esthetic, but perhaps practitioners have also noticed improvements in infants' well-being.

The possibility that babies are reacting to certain foods, either consumed by the mother and affecting breast milk, or in formulas, has been entertained by both conventional and non-mainstream physicians. Dairy products top the list of likely triggers. The physician who has learned autonomic response testing has a distinct advantage in quickly and efficiently identifying the offending food(s).

The technique requires an intermediary (ideally the mother) connecting energetically with the baby by placing one hand on the baby's body. Her free arm is extended horizontally and the physician tests her strength by pressing it downward. The physician then positions the palm of his/her hand over the baby's umbilicus (as in Chapter 4 of my book). Retesting the mother's strength will probably reveal no change in a colicky baby. Specimens of likely food allergens are then placed on or near the baby. The



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mother's arm strength is retested, and if there is a change, the baby is sensitive to that food.

A small but significant part of my practice has for over 20 years consisted of treating colicky babies. The vast majority responds to cranial manipulation (often immediately) or to eliminating the offending food or foods from the mother's diet, or from the baby's formula. These babies and their parents are very satisfying patients to treat.

However in the last year, I have discovered another cause of infant colic that can be treated with neural therapy, namely the umbilicus. (For more information on umbilical interference fields see newsletter [Vol. 1, No. 4, 2006](#).) Interestingly, the umbilical interference field is at least some of the time associated with a history of fetal cord compression. This makes sense to me, as scar interference fields often develop under circumstances of emotional, or some other stress. I would think that cord compression is an extremely stressful event for a little one struggling to enter this world.

Autonomic response testing is performed through an intermediary as described above. The difference is that rather than stimulating the umbilicus with the palm of the hand, the physician simply touches the umbilicus with an index finger. If the intermediary's (mother's) arm goes weak, an interference field is present.

Treatment is injection of a few quaddles of dilute procaine in a circle around the umbilicus. Alternatively, a Tenscam device can be used. It goes without saying the Tenscam is the preferred method in young children.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of Neural Therapy: Applied Neurophysiology and Other Topics

Dear Colleagues:

This month I would like to share a thought-provoking letter from a newsletter reader, Dr Richard Nahas of Ottawa, Canada. It is so well written and so interesting that I am printing it in full with no editing:

I can barely contain myself. I need to share this case with someone who can appreciate its significance. It involves a patient whose left lower leg was amputated after a severe burn turned gangrenous. He has had chronic phantom limb pain. I have treated his stump several times with good results, but the pain has always returned.

Today, I saw him after a 4-5 month absence, and asked him to tell me again where he feels the pain. While describing his phantom limb pain, it occurred to me that he might have an interference field in the part of his 'body' that is missing. I was correct. While there was some weakness over the stump I have treated before, he went totally weak when my hand hovered over an area about 10 inches below his stump, about 12 inches above the point where the surface of his tibia would have been. When treating him with the LaserCAM, he described warm, pleasant sensations that were unlike anything he had felt during previous sessions.

To me, this is an earth-shaking case that changes the concept of neural therapy forever. It shows me that these disturbances are energetic FIRST, and their impact on the autonomic nervous system is a SECONDARY effect. It was a real-life demonstration of Kirlian leaf photography, and was one of those moments that furthered my understanding of the nature of health and disease ... and life itself.

Have you seen such cases before? Is this common knowledge for you? Do you have any thoughts to add?

I have never seen a case quite like this before. What makes it most instructive for me is the precision with which Dr. Nahas identified the initial injury and the dramatic effect of precise treatment. (Incidentally, his patient has had a lasting response with only one repeat treatment on the fifth day). And for readers who are not familiar with the "Lasercam", it is the latest generation Tenscam, an energetic tool that can replace procaine injections in most circumstances.

Osteopaths working at an energy level have similar experiences and can confirm the effect of treatment on the "physical body" by detecting changes in muscle balance, range of motion and body symmetry. Dr Carlos Chiriboga, of Ecuador has also demonstrated to me the capacity of the South American Sintergetica system(See newsletter Volume 6, No. 5) to gather information from the body many inches from the body surface.

At a recent neural therapy workshop that I conducted in Australia, a young osteopath detected an energy disturbance extending at least 6 inches off the surface of the lateral neck and was able to treat it successfully with a Tenscam device.

It is interesting that some in the osteopathic profession are currently attempting to extend the concept of somatic dysfunction to an energetic dimension. Dr Zac



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For neural therapy and advanced healing



Comeaux in the most recent issue of the [Academy of Osteopathy Journal](#) (requires subscription) suggests that the neurophysiological-mechanical model of somatic dysfunction that has served osteopathy so well for over 60 years, needs to be updated to include and explain energetic phenomena.

In my opinion a similar re-thinking of neural therapy is needed. The neurophysiological understanding of the interference field and its relationship to the autonomic nervous system explains much of what we see in clinical practice. However the interference field that Dr. Nahas so clearly described cannot be explained in this way and could not be treated by classical procaine injections. (In my experience neural therapy of the amputation scar and/or the associated lumbar autonomic ganglia can be helpful but is not curative.)

Extending our understanding of neural therapy in this way holds out hope for many new therapies. The intriguing results of combining homeopathics with neural therapy (by procaine injections or energetically) supports the concept of illness being not just a disturbance of anatomy or biochemistry, but also a disturbance of the informational aspects of the body's energy field. Homeopathy has of course been functioning at this level for over two centuries. Neural therapy's unique contribution is it's potential to target that information to exactly where it is needed.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

Last month's newsletter was about interference fields in the body's energy field. This was initiated by a [report from Dr. Richard Nahas](#) (Volume 7, No. 11) of successful treatment of phantom limb pain by neural therapy of an interference field off the patient's body. The treatment was of course not classical procaine injections but rather projection of a scalar energetic signal from a Tenscam device. The idea behind both diagnosis and treatment is that an interference field is not just a focus of electrophysiological instability, but also a focus of incoherence in the otherwise coherent energy field of the body.

I was hoping for comment from readers and they have obliged. Each of these letters adds something more to our knowledge of this subject so I have decided to devote this newsletter entirely to these responses:

Dear Dr. Kidd,

First of all let me thank you for these newsletters. They are always stimulating and open new perspectives on healing.

I was at a Scenar education seminar in Calgary about 6 weeks ago. One of the lecturers described a patient with phantom limb pain where again intuitively the therapist treated the painful "area" in the missing limb with immediate relief of pain. We live and learn!

Brian Bennett MD (Canada)

Comment: Presumably treated with a laser!

Hello Dr Kidd,

I do believe it was my neck with the external energetic interference field at the conference in Australia!

I bought a Tenscam after your conference and throughout the year I feel as though the more I use it the more proficient I am becoming. I believe the reason for this is my ever-improving ability to detect/feel/sense and visualize interference fields. I find that focusing my visual attention on both the physical structures and the energy fields (individually) is achieving much greater results than with the methods I used before.

I generally find interference fields coincide with incidents of physical trauma/impacts mainly present at an energetic level, as was the case external to my neck.

I have a 70-year old female patient who has been seeing me for osteopathic treatment for just over a year now after having someone run into her, knocking her to the ground.



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She definitely experiences the benefits from treatment but we have never really come close to a resolution. It has only been in the last 2 sessions that I have re-attempted using the Tenscam. Now that I have learned to detect interferences of an energetic nature, they were very obvious and her numerous 'musculoskeletal' complaints appear to have resolved, at least at this point in time.

Thank you and warm regards,

Anonymous

Comment: Osteopaths practicing at a high level have a leg up on the rest of us because of their utilization of visualization and other energetic methods of diagnosis.

The following letter is from a veterinarian, whose wife is an acupuncturist. Dr Beltran is a remarkable man (for many reasons) who treats his clients (animals) with neural therapy. He also has an interest in family system therapy and conducts workshops (of human beings!) along the lines of the Bert Hellinger model.

Dear Robert,

As you know my wife, Jordana practices acupuncture at a very high level of understanding, and on several occasions we have noted a most unusual response, about which (in the context of Dr Nahas most exciting report), I can now "come clean ". Jordana treats the human, and if it so happens that their pet, usually a dog has the same complaint i.e. chronic knee pain, one of them does not resolve until the other is successfully treated. Strange but it is acceptable within the context of Rupert Sheldrake Morphic Field study.

Thank you for providing us all with a format for sharing such wonderful observations.

Eddy Beltran DVM (Canada)

Comment: I can vouch for Dr. Beltran's skills. A patient of mine brought her dog (who had cancer) to him for treatment. He did psychotherapy on the dog's owner, who was mourning a personal loss, and the dog recovered!

Dear Robert,

This is a great report and I hope you have had many responses to it. I have been convinced for years that the "energetic body" has great importance and that it has been largely unrecognized by MD's and those doing "Energy Medicine". When using autonomic response testing, I test at 3 levels: surface, 30 cm and 70 cm away from the body. It is not unusual for interference fields to be demonstrated at one and not another level. This process takes time to do but often pays off when a more cursory evaluation is unrevealing. I believe illness starts at the level of the energetic body and can become manifest in the physical body if allowed to continue untreated.

Richard's excitement is refreshing. It reminds me of how I felt when I first started considering these possibilities!

Rob Banner MD (Canada)

Comment: Dr. Banner's techniques remind me of the [Sintergetica](#) methods demonstrated to me by Dr Chiriboga of Ecuador.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

Hyperhidrosis (or excessive perspiration) is not a common reason for patients to consult their physicians. It usually comes up as an incidental symptom, but at times it is severe enough to be taken seriously and even be treated surgically or with Botox injections.

There are two forms: *primary hyperhidrosis* of unknown cause affecting hands, axillae and feet, and *secondary hyperhidrosis* resulting from other medical conditions such as acromegaly, cancer, hyperthyroidism, menopause, spinal cord injury, etc. The secondary type may have the same distribution as primary hyperhidrosis, may be diffuse or affect limited areas of the body.

Primary hyperhidrosis has received some attention from the medical profession with a variety of treatments offered. It even has a self-help group and quite a good [website](#). However as with so many syndromes, there appears to be no understanding of the ultimate cause(s). Treatments are directed at the effects.

However with the neural therapy model of understanding, causes may be found, and even better, cures. I can present two different cases from my practice:

The first was an otherwise healthy, athletic 15-year old girl who presented with primary hyperhidrosis. Her mother reported that even as an infant she had excessive perspiration of her scalp. The sweating worsened with heat, exercise and mental stress. When running her shoes pooled with sweat.

Because her symptoms had begun so early in life, I questioned the mother about birth trauma. Some fetal distress had occurred from cord compression and the child had symptoms of colic in the early months. As readers of a recent newsletter ([vol.7,no.10](#)) may remember, the umbilicus may harbour an interference field as a result of cord compression. And colic may also be a result of vagus nerve irritation (usually from cranial base strain during the birth process).

Autonomic response testing did indeed indicate an interference field at the umbilicus, but neural therapy (using the Tenscam device) resulted in no change in the hyperhidrosis. Re-examination a month later showed interference fields at both the umbilicus and the left vagus nerve (at its exit through the cranial base). Both were treated and this time the patient noted 5 days relief. On the third visit again the vagus nerve interference field was present and was treated.

Circumstances did not permit a follow-up visit for another two months, but by this time perspiration was occurring only when the patient was very nervous. No interference field was found and no treatment offered but at 6 months follow-up symptoms were quite minor.

A second instance was a case of *secondary hyperhidrosis*, this time as part of [Frey's syndrome](#). This is a peculiar condition in which perspiration occurs over the parotid



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For neural therapy and advanced healing



area in response to eating. It often results from parotid gland injury, especially surgery. The theoretical explanation is that autonomic nerve damage, (both sympathetic and parasympathetic) results in abnormal nerve regeneration. However in my patient's case there was no history of parotid gland injury or of the adjacent nerves. Surgery had been performed on the adjacent right temporomandibular joint, but with an interval of 33 years before onset of the sweating. The sweating was preceded by eight years of on-and-off lower jaw dental pain and the dentist had not been able to identify any cause; in fact he suspected referred pain from the temporomandibular joint.

On the first visit, interference fields could be detected in the right tonsil and the lingual side of tooth 4.6 (American 30). Both were treated with a Tenscam device and the pain (but not the sweating) disappeared for a few weeks. On the next visit, the dental interference field was again present and another was detected in the upper nose. Both were treated with the Tenscam and this time the sweating disappeared for three days and the pain for longer.

On the next visit, the above interference fields were not detectable, but a new one was apparent in the lower abdomen, coincident with some unusual constipation and lower abdominal pain. Neural therapy this time resulted in a month's relief of both pain and sweating. One final treatment of tooth 4.6 gave permanent relief of pain and the Frey's syndrome.

Both these cases demonstrate that (at least in some patients) hyperhidrosis is a curable condition. The second case is doubly interesting because it challenges the theory that Frey's syndrome is due to abnormal nerve regeneration. No nerves were damaged, but clearly the autonomic innervation of the skin over the jaw area was stimulated by signals from interference fields in a tooth, and possibly also the nearby tonsil (or superior cervical ganglion) and the nose.



Volume 8, No. 2, Feb. 2013

NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

A 53-year old man from a distant city came to my office for a second opinion with regard to chronic fatigue of ten years duration. He had had numerous investigations and treatments over the years, some of which had helped, but none of which had cured his condition. Chronic Lyme disease had been diagnosed and treated and at the time I first saw him he was undergoing intravenous DMPS and EDTA chelation.

The purpose of the second visit was to review the results of laboratory investigations, but before doing so he complained of unusual headache, malaise, dizziness, nausea and slight elevation of blood pressure beginning one week before. The elevation of blood pressure was the clue that lead me to check his kidneys, using autonomic response testing. Indeed interference fields were found on both sides, which reacted to the presence of both procaine and DMPS.

I report this incident because "overloading" the kidneys or liver is a not uncommon complication of intravenous chelation of heavy metals. Fortunately, it is easily remedied by neural therapy of the affected organs. One treatment is all that is required and the response is rapid. (A more serious case is reported on page 129 of my book [Neural therapy, Applied neurophysiology and other topics.](#))

In my opinion, anyone offering heavy metal intravenous chelation should know how to identify and treat this complication. Even better, they should know how to use neural therapy to detoxify local areas of toxicity, often associated with interference fields, wherever they are found. The kidneys and liver are at risk of localized toxicity because they are excretory organs, but toxic metals will precipitate into any organ or area of the body with disturbed metabolism. Altered pH is probably only one of the reasons for this phenomenon.

Interference fields can develop not only in the organs of excretion but also in the autonomic ganglia with which they are associated. For the liver, the right T8 to T11 ganglia should be checked by autonomic response testing in anyone who appears to have symptoms or signs of liver "stress" - fatigue, depression, headache, nausea, etc., but without an interference field in the liver.

Treating local areas of toxicity should be part of a systemic detoxification plan in patients who need it (more about this in chapters 9 and 10 of my book). However, there are some "ins and outs" to this method and careful monitoring of the patient's response to treatment is important. When treating toxic interference fields, one must be aware that toxic metals will be released into the blood, and if too much is mobilized, the kidneys or liver may then themselves become interference fields, requiring neural therapy. This applies particularly to periodontal tissues and autonomic ganglia, where much mercury can be sequestered, even years after amalgam fillings have been removed.

Another interesting piece of the toxicity-interference field puzzle is the finding by pharmacologists that [inflammation reduces the body's ability to detoxify.](#) There appear to be at least two mechanisms involved, [down-regulation of messenger RNA](#)



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for P-glycoprotein transporter and inhibition of the cytochrome P450 system. At least some of this is mediated by inflammatory cytokines, especially IL-6.

This should be of great interest to anyone attempting to detoxify patients. Chronic inflammation may be a major inhibitor of physiological (natural) detoxification and in fact may be a reason why the patient is toxic in the first place. Top of the list of causes of chronic inflammation (often silent) would be gluten sensitivity where the small intestine lining is under constant irritation if the patient is still consuming gluten. Even after beginning a gluten-free diet, it takes a long time for the inflammation to subside. Also on the list would be chronic inflammation in the pelvis (both women and men), dental infections, chronic sinusitis, chronic infections of all kinds, allergy and autoimmune disease.

Neural therapy is fun and easy to do in relatively healthy people. However it becomes complicated in patients with more complex illness. Patients simply do not respond as well, or responses are not as long-lasting. When this occurs, toxicity should be looked for. Neural therapy can be helpful in detoxification by optimizing function of the excretory organs, especially the kidneys and liver. Efforts to reduce inflammation should be part of a strategy to not only improve patients' health, but also to make neural therapy more effective.

Some comments from readers:

I have seen a surprising number of patients whose healing was incomplete until I probed more closely into their history to identify forgotten wounds. One of these is the puncture wounds in feet from stepping on nails.

I am actually shocked by the number of people who have forgotten that they stepped on a rusty nail. This interference field has proved to be the key to healing in six patients this past year. I suspect that the combined irritation of microbes and metals, along with a physical injury that is usually totally unexpected, is responsible for these wounds' significant effects. Manual muscle testing is often dramatically weakened here, and usually reminds patients which foot was affected. Sensations during laser therapy are also significant, and usually radiate along the entire lower extremity.

The most remarkable thing about this process has been that the interference field is sometimes not noticeable until they are reminded of the event. I am certain that this change is not due to inconsistent testing, and is not due to expectation on the part of the patient. It seems that the memory of the event creates a shift in the nervous system that amplifies the disturbance by virtue of a change in awareness ... in much the same way as ampoules or foods held in the hand can amplify a disturbance.

Richard Nahas, Ottawa, Canada

Re hyperhidrosis: I can report excellent results with biochemic silica 6x. One long-term sufferer had experienced cessation of excess perspiring after her first single-dose use of this preparation. Her almost constant migraines were also negated.

Terry Robinson, Caboolture, Queensland, Australia



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

Have you ever wondered if the "piercing" fashion might affect health? Personally I cringe when I see piercings in the tongue, nose and around the mouth, if only because of the potential for infection. However, infection is probably a small risk compared to other subtler health risks that come with body piercing.

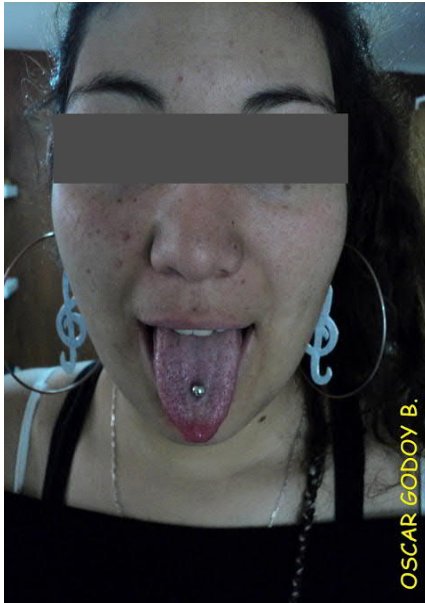
With body piercing, there are two common complications (occurring separately or together): The first is an immune reaction to one or more of the metals in the piercing material. Nickel is the most common allergen, but gold, chromium, and many others including even [titanium](#) can cause reactions in the skin and deeper tissues. This is becoming more and more of a concern with metal joint replacements and dental implants, but any penetration of the skin, or even skin contact can cause systemic or distant problems.

The second potential complication of piercing is an energetic response to irritation of an energetically sensitive location. Oddly, the locations that young people pierce are all energetically sensitive: the peri-umbilical area, the lips, tongue, nose, ears and eyebrows. Of course piercings are human adornments in some ancient cultures, but I sometimes puzzle as to why energetically sensitive areas are the ones chosen for piercing. (I welcome explanations or suggestions from readers.)

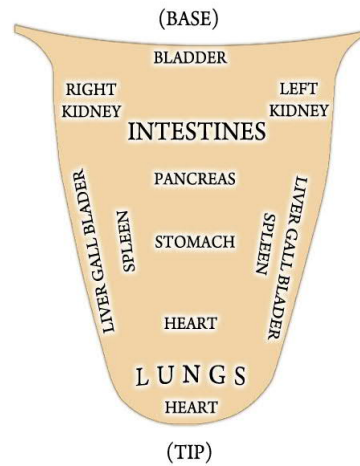
When energetic reactions occur, unpleasant symptoms may arise systemically or in distant locations in the body. A young woman that I know developed mild depression after inserting an earring into her upper external ear (corresponding to acupuncture points for the upper limb). After removing the earring, she felt better; re-inserting it a few weeks later made her feel worse. She had been and is still able to tolerate earrings in the lower ear lobe.

Recently I received an interesting case report from Oscar Guodoy, a physiotherapist and neural therapist in Chile.

A 22 year old girl with Crohn's disease had abdominal pain which had not responded to resection of part of her small intestine 5 years previously. She also had lumbar pain, neck pain, frontal headache and bilateral thenar eminence pain. All resolved with removal of her tongue piercing.



REFLEX ZONES ON THE TONGUE



Although the location of the tongue piercing was in the stomach reflex zone, (somewhat anterior to the intestinal reflex zone), the tongue was clearly energetically important enough to prevent the pain from the Crohn's disease from resolving. Apparently the young woman also had amalgam fillings in her teeth, which Mr. Guodoy felt might be causing nervous system irritation through electrogalvanic currents.

In my experience, piercings are not common causes of interference fields, but they should certainly be considered and checked in any patient with unexplained pain or other medical symptoms.



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NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

This month I would like to report on a case of bronchiectasis, a condition that most of us in industrialized countries do not see much anymore. A half century ago it was often associated with tuberculosis, but nowadays underlying conditions such as cystic fibrosis or various forms of immune dysfunction are more commonly found. Hypogammaglobulinemia, alpha1-antitrypsin deficiency, and autoimmune disease are the common ones. A recent report shows a strong correlation with vitamin D deficiency.

The case I have to report had none of these issues. In fact the patient was an otherwise healthy 52 year-old woman who presented with five years of productive cough, bouts of fatigue and fever, and a feeling of heaviness over her left chest. Only once (10 years before) had she ever had a lung problem, an infection that cleared after a few days of antibiotics.

Investigations led to bronchoscopy during which a half-cup of fluid was removed from a bronchial cavity. Microscopy showed "tuberculous-like" organisms, but not Tb.

The patient's medical history was unremarkable except for a previous caesarian section and an umbilical hernia repair. She was mother of 10 children with five children still at home and had been separated from her husband for 10 years. She was physically active, a runner and a basketball player. Her reason for consulting me was to look for an alternative to an 18-month course of drug therapy "with very grim side effects".

On my first examination she appeared in good health but looked mildly depressed. A careful examination including autonomic response testing indicated an interference field in the mid-precordium. The arm weakening that occurred with touching the mid-chest reversed when the patient touched her own forehead (an indication of an emotional cause of the interference field).

A brief session of "applied psychoneurobiology" (see Chapter 11 of my neural therapy book), using coloured glasses and eye movement desensitization indicated the presence of an unresolved emotional conflict. It seemed to arise from circumstances relating to her husband's adultery of 10 years before. Time did not permit exploration of this so another session was scheduled for 6 weeks later.

(Applied psychoneurobiology is an ultra-quick form of psychoanalysis in which the therapist and patient are guided to the source of the problem through the patient's autonomic nervous system responses. The therapist issues a series of emotionally connected statements to which the patient responds by a strengthening or weakening of an indicator muscle. The autonomic response serves as a sort of "truth detector".)

A second session of applied psychoneurobiology 6 weeks later revealed that the patient did not herself have an unresolved emotional conflict, but rather was carrying one for her husband - an "inability to express himself". Eye movement desensitization wearing the appropriate coloured glasses resulted in a profound yin state and open autonomic regulation. At the close of the session, the patient declared that she



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was aware that her husband had always had difficulty taking responsibility for their (many) children.

Six weeks later she reported "a couple of bad days", with a bruised feeling in her chest, coughing and fatigue. However autonomic response testing indicated open autonomic regulation, no interference fields and therefore no further need for treatment.

She decided against drug treatment and reported recently (1 ½ years later) that her health is good and that she has "no persistent coughing at all". Her latest sputum test showed no evidence of the abscessus mycobacteria present at the onset of her illness and her specialist concluded that there "must have been a lab error in the first diagnosis". "Good news all around" was my patient's opinion.

"Bronchiectasis is not curable" say the textbooks. That may be so, but the autonomic nervous system still may have a major influence in how bronchiectasis or any other disease expresses itself. Even "incurable" conditions should be evaluated for the autonomic nervous system's reaction to the disease process. Neural therapy may still play a role.

Post-script:

I have recently been discussing the terms "neural therapy" and "regulation therapy" with Dr Johanna Osztovcics of the Austrian Society of Neural Therapy. In some circles, regulation therapy has been proposed as an alternative term for neural therapy. However Dr. Osztovcics explains that the Austrian group uses the term "regulatory medicine" as an "umbrella term for all treatments that help the system to re-establish the body's inner resources. This would include acupuncture, osteopathy, homeopathy and good old Sebastian Kneipp's bathtaking".

The question remains: should energetic methods of treating interference fields (e.g. Tenscam and laser - achieving the same results as procaine injections) be called neural therapy or not? Should applied psychoneurobiology, which also treats interference fields, be called neural therapy? What about osteopathy that treats somatic dysfunction, which behaves identically to interference fields?

One solution would be to call the classical neural therapy that uses caine injections, "neural therapy according to Huneke", but some proponents would say that "neural therapy according to Huneke" requires the use of Impletol, (procaine with added caffeine).

Personally I don't feel strongly about the terminology, but I would be interested to hear what others think. I suspect that our German and Spanish speaking readers have already given this much thought.

Letters in response to newsletter on "piercing":

Another interesting newsletter. The role of interference fields are far too often overlooked in conventional and complementary medicine. There are some extraordinary cases on interference fields that have been published in the literature or online. For example:

1) Here is a an interesting case that I have seen presented in person by Dr. Yoshiaki Omura that may be of interest to your subscribers: "Metal Tongue Ring leading to Sudden Cardiac Death after drinking beer." A video (about 39 minutes) of this particular case report by Dr. Omura can be seen at: <http://vimeo.com/10155128>. This



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report demonstrates the potential dangers (as quantified by Dr. Omura using Bi-Digital O-Ring Test (BDORT)) of having foreign bodies in or on the body. The location of the metal tongue ring appears to affect the rising part of the T wave making the heart vulnerable to fibrillation.

2) Dr. Omura has published another interesting paper on interference fields called "Metal Ring on 4th or 5th Finger Markedly Increases both Cardiac Troponin I at Left Ventricle And Cancer Related Parameters such as Oncogene C-fos Ab2 & Integrin Alpha5 Beta1 by 4 to 12 times. Thus These Metal Rings Appear To Promote Both Heart Problems & Cancer." *Acupuncture & Electro-Therapeutics Res. Int. J.*, Vol. 35, pp 45-69, 2010.

John Suzuki
Laguna, CA, USA

I always check for piercings as interference fields and not infrequently find them, especially ear piercings and those of the umbilicus.

My Acupuncture mentor and teacher, Dr. Steven Aung, said referring to piercings and tattoos, "first you tattoo or pierce your mind". There is a reason they are doing this and it often leads to other areas of healing.

Rob Banner MD
London, Ontario, Canada

I also have had several patients with piercings. I found them very resistant to removing the metal. It must be that they are controlled by peer pressure or emotional discord instead of reason.

Charles Crosby DO,
Orlando, Florida, USA

Earrings in the lower ear lobe are tolerated because piercings here are already incorporated into the genetic information through thousands of years of the human being.

But earrings in others parts of the body sometimes are interference fields; - sometimes not. The reason is the same as in many other cases, depending on regulation mechanics or Speransky's second hit. But we have to keep in mind to always look for interference fields from any small objects. The same applies to orthopaedic material, plates, screws, pins, etc. Most of the time they are not interference fields, but in a very few cases I have found they behave like interference fields.

best regards Robert,

Carlos Chiroboga MD
Guayaquil,
Ecuador



Volume 8, No. 5, May 2013

NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

This month I would like to present a case of "abdominal migraine" in a young woman. I enclose "abdominal migraine" within quotation marks because it, like "migraine" is a syndrome, - a shorthand description of a clinical picture, but indicating nothing about its cause or treatment. Syndromes, especially of pain, should always alert the physician to the possibility of an interference field.

Abdominal migraine is rare in adults, and affects perhaps 1 to 4% of children. The picture is episodic mid-abdominal pain, sometimes associated with nausea and vomiting. As with cephalic migraine, these symptoms may be associated with tiredness, anorexia and sometimes headache. The attack may last from hours up to three days. Diagnosis is made by exclusion of organic pathology. Usually a family history of migraine can be found.

My patient was an 18 year-old young woman who presented with a 10-year history of episodic epigastric pain. The attacks were becoming more frequent (every 4 to 6 months), more intense (requiring emergency room visits) and were lasting up to 5 days. They were preceded by a feeling of weakness and hunger. There was no nausea or vomiting or disturbance of bowel function. Eating had no effect on the pain; nor did taking a deep breath.

Multiple investigations including gastroscopy revealed no pathology. A trial of lansoprazole for four months had no effect.

In addition, the patient's energy level had declined over the last two years. She was sleeping 8 hours a night during the week and 12 hours a night on the weekends.

Her past medical and surgical history included tympanostomy and ear tubes as a child, recent wisdom teeth extraction, and pneumonia at age 12.

Physical examination revealed a pale young woman with dark circles around her eyes, slight clubbing of her fingernails, mild dental enamel hypoplasia, and no abdominal tenderness, organomegaly or masses. (The clubbing and the dental enamel hypoplasia suggested gluten sensitivity.) Autonomic response testing indicated an interference field in her large intestine. Additional autonomic response testing indicated deficiencies in iron, zinc, vitamin A, D, B-Complex, and magnesium. The interference field was treated with a Tenscam device and normal autonomic regulation was restored.

Because of the fatigue, blood testing was performed which confirmed multiple nutritional deficiencies: (vitamin D=50, vitamin A=1.17, ferritin=42). Stool testing for antigliadin IgA was positive, indicating gluten sensitivity - the most likely underlying cause of the nutritional deficiencies resulting from malabsorption. The patient was advised to start a gluten-free diet.

Four months later the patient (who lives in another country) reported a "radical change in (her) strength and energy levels". She had had no further attacks of



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pain or the symptoms that lead to attacks.

There were a number of unusual aspects to this case. The first was the increasing severity and duration of the attacks with age. "Abdominal migraine" typically subsides with maturity, although it often transforms into the more typical cephalic migraine. The second unusual feature was the fatigue that had developed over the preceding two years. And another was the interference field found in the large bowel, a location inconsistent with any current or previous history of problems.

I suspect in this case that the good response was as much due to the elimination of gluten from the diet as due to neural therapy of the large intestine. Although the best-known area of the gut to be affected by gluten sensitivity is the small intestine, gluten sensitivity can affect any part of the GI tract from the mouth to the anus. The most symptomatic manifestation in the large bowel is ulcerative colitis, but microscopic colitis, polyps and cancer may also be present. The fact that this patient had no large bowel symptoms does not mean something was not occurring there.

As Speransky pointed out years before neural therapy was even discovered, any irritation of the nervous system can cause symptoms anywhere in the body. The irritation can range from the electrical instability of a scar to an immune or inflammatory irritation anywhere in the body. The manifestation of the process is not dependent on where the irritation occurs, but rather on pre-existing conditions, e.g. genetics, "tissue memory", or biochemical milieu.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

Neural therapy is unique (as far as I know) among medical systems in its identification and treatment of interference fields. Its discovery by Franz Huneke in 1941 was through clinical observation. Only later did a scientific explanation come forward. Because the discovery of interference fields was intimately connected to the effect of procaine, and because procaine was known to affect nerve cell membranes, **an electrophysiological explanation** was a natural conclusion. Subsequent measurements of electro-galvanic potentials in interference fields confirmed the presence of disturbed electrophysiology.

When neural therapy finally made its way to North America, physicians familiar with osteopathy recognized that "**somatic dysfunction**" **resembles interference fields in many ways.** (Somatic dysfunction is a localized disturbance of body mechanics associated with autonomic nervous system changes.) Both neural therapy and osteopathy are related to autonomic dysfunction, both can create remote disturbances and both can be treated with procaine injections. In my opinion, somatic dysfunction is another form of interference field.

In more recent years another model of interference fields has been proposed. Energetic testing (e.g. autonomic response testing or ART) has demonstrated that **interference fields coincide with disturbances in the body's energy field.** In addition, energetic treatments, such as those provided by Electrobloc, laser and Tenscam devices are as effective as procaine injections in treating interference fields.

However there is yet another model of interference fields that has its virtues. This is an old one, the concept of **nervous system "irritation"**. This term was used by the great Russian scientist **AD Speransky** in the 1930's several years before the discovery of interference fields. He observed that irritation of the nervous system anywhere in the body could trigger complex behaviors or even diseases that had been lying dormant in the body as "tissue memories". In his animal experiments, he first sensitized the animals with sub-lethal doses of various infectious agents such as rabies, tetanus or diphtheria. Then months later after the animals had recovered, he irritated the nervous system by intramuscular injections, by severing nerves and applying various toxins such as formalin or croton oil, or by implanting small glass balls or rings into the midbrain. The response of the nervous system was always the same; the disease for which the animal was sensitized was reproduced. The type and the location of the irritation made no difference in the response. Speransky carried this concept of irritation one step further by injecting **systemic toxins** such as mercury and bromide salts intravenously. These also triggered the same sort of complex behaviors and diseases. **I find this phenomenon especially interesting (and practical) in neural therapy, because it alerts us to the importance of systemic and other factors in "irritating" the nervous**



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system.

I present here a case which illustrates this triggering of an old memory by a non-specific irritation:

*A 53 year old man presented with recurrence of an old problem - **right upper shoulder, chest and low back pain** of two months duration without any preceding history of trauma or strain. I knew this man well and had seen him from time to time over the years with a similar condition: recurring right upper shoulder pain associated with interscapular pain and depression. Early on I discovered that his symptoms were caused by an **interference field in his liver usually due to organic solvent exposure** in his work place. He responded to neural therapy of his liver (segmental therapy) combined with detoxifying agents such as chlorella, vitamin C, garlic, etc.*

*However his problems continued even after he left this particular work place and I then discovered that his relapses coincided with **excess alcohol consumption**. Again liver segmental therapy, or T9 sympathetic ganglion blocks gave him relief combined with detoxifying agents. But on this most recent visit, the pain distribution was more widespread and he denied any consumption of alcohol for over 7 months. A search for interference fields in the usual places was fruitless.*

*It was then he mentioned that he had had for the first time **an attack of gout in his right first toe a month before the onset of his right shoulder and interscapular pain**. No interference field could be detected in the usual places with autonomic response testing. However **an interference field was found in the right L3 sympathetic ganglion**. This was treated using a Tenscam device and open autonomic regulation was achieved.*

In my opinion the right first toe triggered the L3 sympathetic ganglion interference field. The L3 sympathetic ganglion may also have been affected by **summation** with the nearby chronic (often subclinical) pattern created by the liver and related autonomic structures. **Summation** of the toe interference field with that of the liver probably explains the wider distribution of the pain.

This case is a reminder that **recurrence of an old problem may be caused by an entirely different irritation than the one initiating it in the first place**. Migraine sufferers are well aware of this: migraines may be triggered by a food, a change in barometric pressure or a change in stress level. We need to be open-minded about what may be causing a recurring problem and not just focus on what caused it the first time.

This young patient came to me for another problem, but mentioned that she was having nosebleeds, something entirely new for her. An interference field was found by autonomic response testing in her left sphenopalatine ganglion. Associated with that was an interference field in this tiny piercing in her nose.



POSTTRAUMATIC CONTRACTURES

A. D. SPERANSKI

STUDIES WERE UNDERTAKEN ON the nature of posttraumatic contractures. The neural or reflex origin of contractures has been taken for granted since the reflex character of posttraumatic contractures has been proved by careful-clinical experiments of Molotkov, Novotel'nov, Leriche, and Shamov. The source of the pathologic reflex contracture may lie in the sympathetic or spinal nerves. An analysis of the available literature suggests that both points of view are probably correct. Some posttraumatic contractures are not the result of scars, and finally, others occur after superficial soft tissue wounds without injury to large nerves. These are called "hysterical" contractures. They may also occur after protracted immobilization, especially in plaster casts. In the first case, deep irritation is apparently absent; in the second, the local disturbances follow pressure and irritation from interrupted circulation in tendons, muscles, and joints.

Work was carried on for several years on dystrophic processes in the nervous system produced by various methods. New facts have been gathered by S. I. Frankstein in the prewar period. The study was based on the Sherrington pattern of "decerebrate rigidity." The cat was used because decerebrate rigidity is pronounced in this animal. The animal was anesthetized, skull trephined, carotids ligated, and blunt separation of the brain done in the region of the tentorium. Such interference produces contracture of an extensor type due to disturbance of normal tonicity. This may last hours and days. The whole phenomenon is attributed to irritation of the "red nucleus" (Sherrington, Magnus), or its removal (Beritov).

Both central and peripheral irritation was investigated in order to ascertain in what manner extensor rigidity was intensified after external influences. It was noted that the side on which the animal lies is always under greater tension than the opposite. We investigated other forms of peripheral irritation likewise related to the proprioceptor but of a more specialized character. A local inflammatory process might be such an irritation.

Experimental procedure: 1-2 drops of turpentine was injected subcutaneously on the posterior surface of one paw. An abscess developed and within 3-5 days the cat "favored" the injured paw and walked on three legs. The abscess sometimes reached considerable size and ulcerated.

After decerebration, the body and extremities were affected with extensor rigidity with the exception of the injured part. The affected paw either remained soft and pliable in all its joints or developed flexor rigidity. Prolonged observation



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

Almost two years ago I wrote a couple of newsletters on **the relationship between interference fields and autoimmune disease**. One was primarily about **psoriasis** ([Volume 6, No. 11](#)); the other was about **rheumatoid arthritis** ([Volume 6, No. 12](#)). Both cases responded well to neural therapy, although the course of the second one was complicated.

In the practice of neural therapy we all hope for those "and they lived happily ever after" endings. And sometimes they occur. However in real life, it is not always so simple. I intend in this newsletter to provide some follow-up on these two patients and to present another case that demonstrates how complex these inter-relationships can be.

The first case (the young woman with psoriasis) was the simpler. **Four sessions of neural therapy** over a period of 6 months treating the left sphenopalatine ganglion, the nose and the transverse colon **resulted in an almost complete cure** not only of her psoriasis, but also of her irritable bowel syndrome. However, at least part of the credit must be given to adopting a gluten-free diet. I have found that **in autoimmune disease eliminating dietary gluten is essential for any hope of success**.

The second case (the young engineer with rheumatoid arthritis) has had a bumpier ride. At first I saw him every two weeks, but in the last year every month or so. As you may remember from the previous newsletter ([Volume 6, No 12](#)), there seemed to be many triggers that would "turn on" his joint pain and swelling. These included **interference fields in his wisdom tooth space** (a site of previous infection), his **submandibular ganglion** (the associated autonomic ganglion), his **left upper arm** (a site of vaccination), his **small intestine, stomach, gastro-esophageal junction and anus** (all irritated by food sensitivities). These were all treated, but **he did not make lasting progress until his tooth space was treated with the Lasercam, and he gave up eating gluten, dairy products, beef and eggs**. He is now virtually free of pain, able to perform hard physical labour, is off his prednisone and is taking only a small dose of methotrexate. However he does need to have his wisdom tooth space treated every month or so with the Lasercam or his joint pains relapse. He is improving month by month and it is our hope that he will soon be able to stop his methotrexate.

The third case I want to present is of a **65-year old woman with rheumatoid arthritis of 7 years' duration**. I began to see her two years ago when in addition to diffuse joint pain she was also complaining of fatigue and gastrointestinal symptoms secondary to her many medications. These included Sulfalazine, Naproxen, Plaquenil (hydroxychloroquine), Lamazaprole and Effexor (venlafaxine). Interference fields were found in the nose and gastro-esophageal junction and treated by neural therapy to no effect. Modification of diet (eliminating gluten, dairy, beef and lamb), reducing sugar and dense carbohydrates, nutritional supplementation (especially of zinc and vitamin B6), improved her energy and



reduced her joint pain. An interference field at the left T10 sympathetic ganglion, (associated with groin pain echoing that of an inguinal hernia from 40 years before) was treated and joint pain improved even more. In fact **she was feeling better than she had in years when she had a sudden relapse in February of this year** (6 months ago).

Close questioning revealed that the relapse occurred within a week of replacement of an amalgam dental filling. Autonomic response testing had previously indicated that mercury from her dental fillings might be playing a role in her rheumatoid arthritis, and this relapse confirmed it. At the time of this writing the patient is preparing to have her dental amalgam replaced with composite material and undergo a mercury detoxification program.

Again we return to Speransky! His experiments in the 1920s and 1930s showed that any irritation of the nervous system, whether locally - of a nerve, tooth or organ, or systemically - by introducing a neurotoxin, (and he experimented with mercury) can trigger a tissue memory. In this case the rheumatoid arthritis was for all intents and purposes in complete remission. **Mercury, from a dental amalgam replacement, was enough to stir up the latent rheumatoid arthritis and make it active again.**

The older German neural therapists advised **always to search for interference fields even in chronic well-established disease.** Like Speransky, they recognized that the chances of influencing the progress of a disease is much smaller once it has passed a certain point. (**At a certain point, a disease "escapes" from the influence of the body's regulatory mechanisms and takes on a life of its own.**) However the point at which this happens is never clear and the patient should always be given the benefit of the doubt.

And then **there are some cases, where the body's disease lives "on the edge"**, neither progressing in severity, nor responding lastingly to treatment. The last two cases presented in this newsletter fall into this category. They also demonstrate that **treating these patients "on the edge" requires paying attention to a multitude of factors, any of which can limit response to neural therapy or even push the patient "over the edge"**.

For experienced neural therapists: Another "Midwinter Neural Therapy Retreat" is being planned for **February 7th and 8th, 2014** at Wakefield Quebec (about ½ hour drive north of Ottawa, Ontario, Canada).

The format will be similar to previous retreats - 2 days in a cosy country inn at the coldest time of the Canadian winter - discussing neural therapy and topics related to neural therapy in an informal relaxed environment.

Our featured guest this year will be **Dr. Pablo Koval**, author of the recently published book "**Neural Therapy and Self Organization**". Mark it on your calendar. More information will be available soon.

A free Spanish language neural therapy newsletter is available, published by D. David Vinjes of Barcelona, Spain at <http://ww/terapianeural.com/>. Sign up at the site! Discussions are underway with regard to translating both English and Spanish literature. Feedback with regard to interest is invited from you, the readership of this newsletter.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

In 2001, I wrote an article entitled "[Osteopathic treatment by injection: A comparison of osteopathic manipulative treatment and neural therapy](#)". The piece was published in the American Academy of Osteopathy Journal and directed at the osteopathic profession. Its subject matter addressed primarily **the theoretical bases** of both disciplines which have a number of similarities. A main point of the article was that somatic dysfunction is a form of interference field.

This month I plan to return to this subject but rather than discuss theory, examine **practical aspects of detecting interference fields using osteopathic as well as other more established techniques**. Some of this is covered in Chapter 4 of my book [Neural therapy: Applied neurophysiology and other topics](#), but I would like to extend these ideas with experiences that I have accumulated over recent years.

The **most distinctive characteristic of osteopathy linking it to neural therapy** is the principle that somatic dysfunction anywhere in the body can be the cause of a symptom anywhere else in the body. For example a "shear" of a sacroiliac joint may be the primary causative factor in a chronic headache. Or a cranial lesion (e.g. compression of a temporo-parietal suture) may be the key to understanding low back instability. To be sure, symptoms are more common in the segment where the somatic dysfunction is found, just as interference fields generally provoke symptoms nearby, but the principle still holds. **With an unexplained symptom, the whole body must be searched** - in the case of osteopathy for mechanical disturbances, in neural therapy for the usual kinds of interference fields, e.g. scars, teeth, organs, etc.

That somatic dysfunction is a form of interference field can be demonstrated in two ways: by **autonomic response testing and by response to treatment**. Touching a level of the spine corresponding to a vertebral somatic dysfunction will cause weakening in an indicator muscle. **Quaddles of subcutaneous dilute procaine or administration of a Tenscam will treat somatic dysfunction as effectively as will manipulation.**

However there are exceptions. Some somatic dysfunction extends over too large an area to be detected by autonomic response testing. This occurs with restriction of a group of muscles, as with the respiratory diaphragm or the pelvic floor diaphragm. **These cannot be detected by autonomic response testing**, but if untreated still block regulation and make autonomic response testing difficult.

Some osteopaths routinely treat the "diaphragms" before more specific treatment. There are several of them, including the thoracic outlet, the cranial base, and the tentorium cerebellum. Others only treat them if indicated. Indications that they need treatment include an inordinate degree of local restriction of craniosacral (primary respiratory) movement, or



the presence of "**arcing**" in a diaphragm.

Arcing is a phenomenon described by the late John Upledger DO in his book *Craniosacral therapy*. **It is a subtle pulsation at about 1 Hz emanating from a specific locus - often a site of previous injury.** The arc refers to the shape of the wave, which is circular and like the spherical waves in a pool of water indicate where the fish jumped or the stone was dropped.

Upledger described arcing in mechanical terms, as a pulsation that could be felt in the tissues. However with practice it can also be felt "off the body" or even seen by the "mind's eye". This might be an intimidating concept for those not trained in manual therapies or for those unfamiliar with energetics, but it does not have to be. Dosch's *Manual of neural therapy according to Huneke* describes how **the old neural therapy masters had an intuitive sense of where to find interference fields.**

I believe that this intuitive sense is available to everyone. It is a matter of listening to one's own intuition or even gazing at the patient's body. One should not be ashamed to "guess". A guess in an educated, empathetic and sensitive person will often lead to the right solution.

How do we treat arcing? The osteopathic method is to place one's hands lightly on opposite sides of the patient's body - usually above and below, with the patient supine. The hands should be passive and in "listening" mode. The tissues will very subtly begin to move ("unwind") and the hands should simply follow. The movements may reproduce the strains that occurred with the initial injury, or may move in one direction and then another. **At a certain point, usually within a few minutes, the tissues will "go still";** the patient may feel a generalized relaxation and the treatment is over. For those physicians trained in cranial osteopathy (or craniosacral therapy), the craniosacral rhythm will first stop and then increase in amplitude and be more relaxed. Alternatively, autonomic response testing will often indicate "open" or unblocked autonomic regulation.

For those disinclined to try manual therapy, quaddles with dilute procaine over the affected region or administration of the Tenscam device may provide a satisfactory response. However I find manual treatment more satisfactory, if only because I can feel the patient's response.

I believe all neural therapists can benefit from learning some osteopathy and osteopaths will find that they can offer more to their patients by learning neural therapy. Both systems are intimately connected to autonomic nervous system function and are more philosophically similar than is commonly realized.

For experienced neural therapists: Another "Midwinter Neural Therapy Retreat" is being planned for February 7th and 8th, 2014 at Wakefield Quebec (about 1/2 hour drive north of Ottawa, Ontario, Canada).



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For neural therapy and advanced healing



The format will be similar to previous retreats - 2 days in a cosy country inn at the coldest time of the Canadian winter - discussing neural therapy and topics related to neural therapy in an informal relaxed environment.

Our featured guest this year will be **Dr. Pablo Koval**, author of the recently published book "**Neural Therapy and Self Organization**". **Dr. Olef Kuhnke**, a leading European neural therapist, will also be participating. Mark the dates on your calendar. More information will be available soon.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

I am beginning this newsletter on a flight home from the **Austrian Neural Therapy Society's biannual meeting in Vienna**. It was my first experience of a European neural therapy meeting and I have much to report.

I learned a great deal at this meeting. The lectures presented some entirely new (for me) scientific and clinical ideas, the highlights of which I will mention below. I also learned about neural therapy education in a number of European countries and the strategies driving these educational efforts. The politics of medicine can be complicated anywhere and European neural therapy is no exception. I will perhaps write more about this another time because it has practical importance even for those of us who do not live in Europe.

Austria is one of the smaller European countries with a population of only 8 million. Because it is a smaller country, the neural therapy society is smaller than some others, but makes up for this with a **creativity and collegiality** that was impressive. Obviously others feel the same way; the meeting attracted physicians from Switzerland, Germany, Greece, Spain and Turkey. Some of these attendees confided to me that the Austrian society was one of their favourites because of its **openness to new ideas**.

Most of the lectures were delivered in German. A simultaneous translator was provided for the few of us who did not speak German. The lectures in English did not need translation as everyone attending seemed to understand English.

Now for a few "pearls": There were two lectures on the pharmacology of procaine, with special attention to interaction with other medications. One eye-opener for many of us was that **the use of caine anaesthetics is contraindicated in the presence of sulfonamide allergy**. This contradicted the experience of many in the audience, but nevertheless the injunction exists (at least in Austria) and could create medico-legal problems should an adverse reaction occur.

There were two lectures on anatomy: One was on the **"danger zone" in the neck**, just posterior to the pre-vertebral fascia. This space is continuous with the epidural space and one to be avoided in neck injections. Some neural therapists are using **ultrasound guidance** for injections, especially in the upper neck. A lively discussion of its pro's and con's ensued but the consensus was that **knowledge of anatomy outweighs the value of guided imagery**.

The other anatomy lecture was on the extracellular space (or "matrix" as described by Pischinger). This demonstrated that pluri-potential fibrocytes manufacture cells according to conditions (neurotransmitters, mechanical stresses) in the extracellular space.



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One of the more intriguing lectures was on the **biochemical properties of the interference field itself**. According to **Dr. Papathanasiou**, of Athens, Greece, **the interference field is a focus of "silent inflammation"**. Each interference field releases neurotransmitters (peptides, cytokines, endocannabinoids) that are able to signal not only the nervous system but also the endocrine and immune systems. The "profile" of these inflammatory mediators may differ between interference fields and may even change in the same interference field with time. Dr. Papanathisiou has contributed some of these ideas to one of the major new (German) neural therapy textbooks: "**Handbuch Neuraltherapie**" edited by **Stefan Weinschenk**.

Speaking of German neural therapy textbooks, there are three newer ones (See letter from Lorenz Brassel below.) I have in my possession a copy of Stefan Weinschenk's book and it is impressive indeed - hardcover, over 1100 pages, with multiple contributors, and numerous photographs, pictures and tables. I have not yet seen the other two textbooks but did meet **Dr. Fischer** and **Dr. Barop**, both of who delivered stimulating and thought-provoking lectures at the conference.

Apparently these books have not been translated into English because the publishers believe that the market is too small. I believe that they have under-estimated the possibilities. I would encourage my newsletter readers to write the publishers of Weinschenk's book asking them to have it translated and published in English. The person to write is: [Marko Schweizer](#), Acquisition editor, CAM, Elsevier Publishing.

My contribution to the conference was a lecture on Speransky's legacy and his continuing relevance even 80 years after the publication of his "Basis for the Theory of Medicine". **Dr. David Vinyes** of Barcelona gave an overview of the status of neural therapy in Spain. The Spanish neural therapists are an energetic group and are making great strides in educational programs, certification and published work. I was somewhat surprised to learn that despite their proximity to the German speaking countries that the language barrier limits communication, just as it does for English speakers.

Now for some letters:

I'm a recently graduated neural therapist from Cali, Columbia.

My main experience has been as a Rolfer for 16 years. I believe that the revolutionary ideas of Dr. Ida Rolf about fascia, helps a lot to understand the body connections and integration. Her book is: Rolfing: the integration of human structures.

That's my suggestion.

Best Regards

Silvia Serber



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For neural therapy and advanced healing



Are you aware of Dr. Hamer MD's New German Medicine? He has arcing literally observable on CT scans of the brain. His teaching team is located in your country.

Dr. Koval's book is great! Keep up your great work

JJ Adams MD Sedona AZ USA

My reply:

I am aware of Dr. Hamer's New German Medicine, but I don't think the arcing that I describe and that demonstrated by Dr. Hamer are the same things, although both radiate in spheres. I cannot speak with authority on Dr. Hamer's work, but as I understand it, CT scans operate in the EMR dimension. "Arcing" is more likely a subtle energy, which would not be picked up by CT scanners.

Dr. Adam's reply:

Thank you for replying. However I must suggest that Hamer foci are a lower harmonic of your osteopathic "subtle energy" arcing perhaps known once as spirit.... Interference fields can be dense and also of a finer dimension. Thanks to you and Dr. Koval I read Dr.Ho. Our coherent energy field extends throughout all corporeal time-spaces down to 10x-10meter and 10x-12 watt/cm² (last supplied by Russian Ph.D)

In Germany, Switzerland and Austria, neural therapists think that the Dosch-book is a bit over the hill... We read: Lorenz Fischer, Hans Barop or Stefan Weinschenk, who all made books that meet the standards of the 21st century.

Regards,

Lorenz Brasse



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of Neural Therapy: Applied Neurophysiology and Other Topics

Dear Colleagues:

At the recent Neural Therapy conference in Vienna, Austria, three case reports were presented. All three were complex and required **many months of pain-staking and careful neural therapy for success**. Potential interference fields were searched for all over the body and treated in the classical way, with dilute procaine injections. The patients' responses guided the process. Positive responses proved that the potential interference fields were significant. No response generally indicated that the potential interference field was a "red herring" (lead to nowhere).

I was impressed by the patience and skill shown by the presenting physicians, but also by **the trust exhibited by the patients** who were willing to endure so many injections. In countries where neural therapy is less well known, persuading patients to accept numerous injections (many fruitless) is more of a task.

This slow, systematic approach is in contrast to that producing the "**lightning reaction**" for which neural therapy is famous. Much has been made of the many lightning reactions obtained by the neural therapy pioneers of 60 or 70 years ago. There seem to be less now. The European neural therapists that I spoke to about this phenomenon blame **poor regulation in the "ground system"**, i.e. a sluggish response to stimuli because of pervasive toxicity, hormonal disruption and malnutrition in the extracellular space of our patients.

American osteopathic physicians have told me the same thing. Osteopathic manipulation was more consistently effective in previous (healthier) generations.

The slow patient application of neural therapy is particularly important in treating certain chronic infections. [I have already written about treatment of periodontal infections](#) (Vol.4, No.10, Oct.2009), which generally take a number of treatments. However almost all settle down within two or three weeks of twice-weekly neural therapy treatments (whether by injection of procaine with a homeopathic or by Tenscam (+homeopathic) treatment.

Here is another case of chronic infection seen recently in my office, this time of a woman with an infected pilonidal sinus:

*A 33 year old woman presented with an episode of **acute low back pain** that had begun suddenly 2 days before when getting up from her bed. There was a great deal of muscle spasm and her upper trunk was translated noticeably to one side.*

This was a recurring problem for her - each time precipitated by a minor unguarded movement and then lasting for several days. Spinal manipulation was helpful at times but



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did not seem to prevent further recurrences. `

*On this occasion the patient mentioned that she was having one of her recurring "flares" of **an infected pilonidal sinus**. Typically, a painful swelling would develop and then rupture, discharging pus before settling down, until the next time, - sometimes only days later. Surgery had been offered to her, but (searching the internet) she realized that [recurrence after surgery was common](#).*

Autonomic response testing (ART) indicated that the pilonidal sinus was an interference field and that it might respond to an isopathic nosode (Sanum remedy - Notakehl). The interference field was treated using the Tenscam device with a vial of nosode placed over the infected sinus.

*Drawing upon my experience with dental infections I suggested that the patient return twice a week for assessment and treatment. Within a week the back pain had settled, but more interestingly the patient reported that the pilonidal sinus region was feeling different - "tighter". **After 3 weeks, the "flares" were becoming less frequent** and the interval between visits was increased. On most visits ART indicated an interference field needing treatment but as time went by, the pilonidal sinus appeared on certain visits to be quiescent.*

*At three months, flares were still occurring, but much less frequently, with less pain and **the pus had become thicker and changed colour**. At four months (the most recent visit), there had been no flares in several weeks.*

The Dosch textbook warns that the response to neural therapy of infection may take longer than for an uncomplicated pain problem. Presumably, treatment alters the electrical and biochemical milieu of the interference field but time is needed for these changes to deal with the infection and the inflammatory process. This is consistent with Speransky's finding that the disease process is a chain reaction of biochemical processes, one feeding into the next.

Whatever the explanation, **neural therapy of chronic infection can be effective, but it requires persistence and patience on the part of both physician and patient - no dramatic interruption of body-wide cybernetic loops - simply gradual alteration of the biochemical environment supporting the chronic infection**



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

This month I plan to discuss the use of **DMPS (dimercapto-propanyl-sulfonate) as it relates to neural therapy**. It is a subject that neural therapists sooner or later will encounter, as it is the most powerful chelating agent for mercury. And at least in the industrialized world, mercury raises its ugly head over and over again in the practice of neural therapy.

The most common cause of low-grade chronic mercury toxicity in first world countries is from dental amalgam, either past or present. The typical scenario is

interference fields that do not respond lastingly to treatment, or multiple interference fields, one after another. When this occurs, neurotoxins must be searched for and mercury is one of the most common.

Diagnosis and treatment of chronic mercury toxicity is a complex subject, and I do not plan to discuss this here, (although you can read about it in Chapter 9 of my [neural therapy book](#)). Rather I intend to address the subject of DMPS and its utilization, paying particular attention to safety.

DMPS has been around for a long time. For an **excellent review** by an experienced German physician, [read this](#). the safety of DMPS itself is well documented in the [1000 article monograph "Dimaval"](#) (1997) published by one of its manufacturers. And in Germany it is now an over-the-counter drug.

Nevertheless [reports have surfaced in the internet](#) (mostly by patients who have been hurt by DMPS injections) indicating that **it is not as safe as we have been lead to believe**. I take these reports seriously and believe that we can and should learn from them.

DMPS is a powerful chelator. I have used it many thousands of times over at least 20 years and I have seen its benefits over and over again. **Adverse reactions are rare if adequate precautions are taken**. The most important thing to remember about DMPS is that it mobilizes mercury but ultimately the kidneys and liver must deal with this mobilization. **This means that the physiological detoxification functions of the liver and kidneys must be working optimally to deal with the pharmacological movement of mercury.**

This preceding statement is in some ways a paradox, as the patients that we see having trouble with mercury toxicity have almost by definition problems with detoxification. The opposite - very old patients with mouths full of amalgam have survived because of their excellent detoxification ability.

In practice, when confronted by a patient who is mercury toxic, **the first task at hand is to assess the patient's detoxification capacity**. This means careful study of the patient's



biochemistry and sometimes specialized testing, such as the [Quicksilver Tritest](#). Last, but not least, **the patient should be checked by autonomic response testing for interference fields in the liver and kidneys and associated autonomic ganglia.** Only after careful preparation, sometimes taking many months, should DMPS be administered. And soon after administration, the excretory organs should be rechecked by autonomic response testing to make sure that they are not overwhelmed by the mercury load.

A recent patient experience demonstrated some of these vulnerabilities:

*A relatively healthy 49-year old woman decided to have her five dental amalgam fillings replaced because of **mild chronic fatigue and low-grade hypertension**. After careful biochemical workup and preparation, a well-trained biological dentist removed and replaced her fillings with composite material in one session. Immediately afterward she came to my office for an intravenous infusion of 25 gm vitamin C and 250 mgm of DMPS in 500cc of Ringer's lactate. After the infusion she was carefully checked for interference fields and discharged with the advice to return immediately if any adverse symptoms should occur.*

***One week later she returned "not feeling that great", with fatigue and a mild elevation of blood pressure.** No interference fields could be detected at first, but after another intravenous infusion of vitamin C, kidney interference fields could be detected bilaterally and were treated by neural therapy. **She felt immediately "much better"**. Interestingly the lab urinalysis after the first DMPS injection showed almost no mercury - suggesting that the kidneys had refused to cooperate. A second DMPS injection 5 weeks later resulted in a significant excretion (12 micrograms/g creatinine in a 6 hour collection).*

This patient has gone on to recover nicely, but she stands as a warning that DMPS must be handled with skill and respect even after careful preparation. The mild hypertension was a warning sign. Hypertension can be caused by mercury toxicity and weak kidneys can impair detoxification. As in a [previous report](#) on this subject, **I feel that DMPS should only be used by those able to deal with its complications. Neural therapy is probably the best tool that we have to make DMPS utilization safe.**



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

This month I would like to discuss the subject of **constipation** and **neural therapy's role in its treatment**. The Dosch textbook suggests a number of injection techniques including epigastric and coeliac plexus injections, quaddles to the small and large intestine Head zones, infiltration of appendix scars and a variety of other locations including the presacral areas, pelvic plexuses and paranasal sinuses.

Although knowledge of these locations is useful to bear in mind, **I prefer to spend more time thinking about the ultimate causes of constipation before embarking on treatment**. Constipation occurs for a reason, and understanding what the reasons are is essential for any long-lasting benefit.

When I started researching this subject, I was somewhat surprised to find 18,991 papers on PubMed in response to the search-word "constipation". I had thought that it was a neglected subject in medical research, and obviously, I was wrong!

So rather than trying to summarize the literature, I will simply list some **common causes of constipation** that I find in my practice, before moving on to the neural therapy part. Close to the top of my list would be **magnesium deficiency** - typically a "lazy bowel", with tight muscles all over the body (check for tight hamstrings and leg muscle cramps). Next would be **gluten and other food sensitivities**. (It is amazing how many cases of chronic constipation resolve on a gluten-free diet.) Lower on the list would be commonly recognized conditions in mainstream medicine such as **hypothyroidism, medication side effects, low fibre diet, lack of exercise, painful anal conditions such as fissures or thrombosed haemorrhoids, and medical illnesses affecting the bowel directly or indirectly**.

When we consider nervous control of the bowel, **abnormal somato-visceral reflex** from somatic dysfunction may be a cause of constipation. Paralytic ileus associated with compression fracture of L1 or abdominal trauma is well recognized in mainstream medicine. However constipation can be caused by much less severe trauma, such as **assomatic dysfunction of upper lumbar vertebrae or sacroiliac joints**. When these are present, manipulation or neural therapy of the affected structures can immediately restore normal bowel function.

Viscero-visceral reflexes are neurological pathways between viscera. Signals may pass from one organ system to another, e.g. bowel and urinary bladder, but may also connect one part of an organ system to another part. (We all see patients with abnormally active gastro-colic reflexes.) Occasionally treatment of an interference field at the gastro-esophageal junction can correct the opposite problem - constipation.

The following is a case of constipation successfully treated by neural therapy of an



interference field at the anus, albeit an atypical one.

*A 48-year old man presented with a bewildering variety of symptoms, most of them beginning eight months before, subsequent to a fall and cerebral concussion: sore muscles and joints, fatigue, head pressure, right-sided body numbness, right sided tinnitus, mental confusion, balance disturbance, bleeding from the gums of the right side of his mouth, constipation and pain of the anus and penis. **Of all these symptoms, the constipation and anal pain were the most distressing.***

*His family doctor had already suspected Lyme disease, but laboratory testing was equivocal. No further testing had been offered, so the patient was examined (by me) using autonomic response testing. **Interference fields were found at the right mid-cervical ganglion and the anus.** The interference fields were then challenged with Klinghardt's [diagnostic slides of Lyme associated organisms](#). The anal interference field autonomic response reacted to the presence of herpes simplex Type 1.*

The anal interference field was treated with a Tenscam device, directing "energy" through a herpes zoster nosode, held directly over the anus. (Neural therapy injections of dilute procaine with the equivalent homeopathic remedy would have produced an equally effective response. (See page 60 of [my book on neural therapy](#)).

*The patient obtained **a few days relief of his constipation, penis and anus pain.** A very grateful patient returned for **a second treatment that gave him two weeks relief.** Further treatment is ongoing.*

[A number of reports of urinary retention and \(less so\) constipation caused by herpes zoster](#) have been reported in the literature. These are generally thought to be caused by herpes irritation of the bladder and bowel themselves. This may be so, but this case indicates that **interference fields of the anus should be searched for** as well, and if found, treated by neural therapy.

Constipation has many potential causes. Rather than simply treating symptomatically, wise physicians should search for the cause(s). **Interference fields are among the possible causes** and should be searched for, if only because treatment is so effective.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

The fact that you are reading this newsletter tells me that you believe continuing medical education to be important. It also tells me that you have likely had a good education. **The mark of a good education is the habit of life-long learning**, not just for the practical knowledge accumulated, but learning for its own sake.

There was a time when life-long learning was a way of life for educated people. Many of the scientific, philosophical and literary achievements of the 17th to the 19th centuries were by amateurs. Up until the 20th century, philosophy was accessible to ordinary educated people and was a common subject of conversation in polite circles.

Ideas were exchanged and circulated in societies and through hand-written letters.

In the 20th century with the rapid increase in number and size of universities, colleges and technical schools, more and more people were able to find employment and devote their lives to study and research. **Scholarship became the purview of specialists and amateurs only rarely were able to take part.**

This has become especially true in medicine. **Knowledge distribution has become a top-down exercise** where specialists (usually from medical schools) dispense information to the less informed. During the twentieth century medical knowledge increasingly became the monopoly of specialists and the regulatory authorities that decide the *standard of care*.

However, another movement in the world of medical education has been taking place.

Medical knowledge is now readily available to everyone, even non-professionals.

Physicians see this every day in their practices where patients arrive with sheaves of Internet information on their own illnesses. It is not difficult for a patient to know more about a medical subject than his or her physician does.

The energetic and curious general physician can also learn more about a subject than the specialists who are supposedly expert in a field. Specialists' activities are often confined to a very small area of their field by the demands of sub-specialization. The generalist who sees a more diverse population may have far more experience in a given specialist's field.

To return to the subject of continuing medical education (CME), **I believe a day is dawning where the truly educated physician (in the best sense) can again play an important role in medical care.** This is in contrast to the current situation where physicians unthinkingly follow a mediocre *standard of care*, conform to algorithms and "guidelines", and treat their patients' numbers (blood pressure and cholesterol levels) with industrial pharmaceuticals.



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The classical values and attitudes that make a good physician are the same as ever, but with the information revolution, the dependence on "experts" diminishes. (To be sure, experts can provide specialized technical expertise, but the general medical and scientific knowledge needed to provide wise, knowledgeable medical care is now widely available.)

So where does the educated physician go for continuing medical education? The answers are not obvious. Mainstream medicine in North America appears to have become the dispensing arm of the pharmaceutical industry and the CME offered by the universities and medical schools reflects that. So what else is available?

An alternative already appearing is **the rise of non-university medical associations and societies studying non-standard methods of medical care.** Associations studying functional medicine, heavy metal chelation, prolotherapy, orthomolecular medicine, ozone treatment, hypnotherapy and many other options are now part of the medical landscape. All of these function much as the 19th century scientific societies did. **They attract the most intellectually alive physicians, those willing to think independently and those who are truly life-long learners.**

At the recent "Mid-winter neural therapy retreat", **the possibility of creating an organization to study and teach neural therapy in North America was discussed.**

The consensus was that this is a desirable goal, but many practical difficulties must first be overcome. The first is to determine how many neural therapists exist in North America. The second is to assess their interest in such a project. The third is to gauge their level of expertise.

So, Dear Colleagues, I am asking that you let us know if you are interested, and in what category you belong: (This is only for those licensed to practice neural therapy.)

1. **Interested in neural therapy.**
2. **Practising some neural therapy.**
3. **Practising neural therapy with enough expertise to accept referrals.**

Please send your name, contact information and above category to either:

- **Michael Gurevich MD** MIGurevich@Gmail.com Long Island, NY, or
- **Gerald Harris DO** zymax61@yahoo.com Fort Worth, Texas, or
- **Jeff Harris ND** drjrharris@gmail.com Seattle, WA,



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

This month I plan to discuss a **"hidden" interference field** - a difficult one to find and even more difficult one to treat using conventional neural therapy techniques (procaine injections or energetic treatments). To avoid misunderstanding, I want to be clear about my definition of interference field: I am proposing *"a focus of nervous system irritation with the potential to create significant pathophysiological effects"*. (This definition is slightly different from the one used in my book where the "focus" is one of "electrophysiological instability".) I am making this change for three reasons:

1. "Electrophysiological instability" has largely been a theoretical concept based on procaine's membrane-stabilizing effect.
2. Somatic dysfunction, as outlined in [my book](#) (page 25) acts very much as interference fields do and also responds to procaine injections, but does not have electrophysiological instability in the sense that a scar or tooth interference field does.
3. Physicians using autonomic response testing know that interference fields can be found "off the body" and treated successfully using energetic devices such as the Tenscam.

This last phenomenon brings up the possibility that interference fields may not be mediated by the nervous system alone. See [Volume 7, No 11 \(2012\) of my newsletter archive](#) for a discussion of this.

So where can this hidden interference field be found? Actually there is more than one possibility, but today I will describe one that has been recognized in osteopathy for many years, i.e. a **cranial base compression**. Cranial base compression is a somatic dysfunction of the cranial base, usually resulting from head trauma. This concept will likely be foreign to those who do not recognize that the skull is a moving structure and that disturbance of this innate capacity for movement can have serious consequences. The cranial base is in close proximity to the brain stem, mid brain and pituitary gland and has important cranial nerves passing through it. In addition, kinesiological reflexes connect skull posture and movement with the rest of the body, so that cranial somatic dysfunction can disturb mechanics anywhere in the body. Detection of cranial somatic dysfunction and its manual treatment is the art of cranial osteopathy. (Craniosacral therapy is a simpler variant.)

From the neural therapist's point of view, cranial base compression is a common cause of blocked autonomic regulation.

Unfortunately cranial osteopathy is a skill requiring a considerable investment of effort and time to master. Yet cranial base compression is not rare and may have effects that defeat the best efforts of the most skilled neural therapists. **My advice until recently is that all**



patients with musculoskeletal and other problems beginning after a significant head injury (even many years before) should be referred for assessment to a cranial osteopath or skilled craniosacral therapist.

Recently I have learned of an alternative method, demonstrated to those attending the Mid-winter neural therapy retreat by **David Watson MD** of Vancouver, British Columbia. His technique derives from Applied Kinesiology but is not part of traditional Applied Kinesiology training. He was taught this by Don Grant DC of Burnaby, BC who learned it from "an old-time osteopath".

Here is Dr. Watson's description:

*With the patient lying supine on an examining table, **the physician tests the strength of the hip abductors and shoulder adductors. If weakness is found in all 4 extremities, the patient most likely has a cranial somatic dysfunction.** When testing the upper limbs the elbows must be kept straight. When testing the hip abductors a good deal of force may be needed to detect weakness. (Under normal circumstances it should not be possible to overpower the hip abductors.)*

*To confirm somatic dysfunction involving the sphenoid, the patient places his or her 2nd and 3rd fingertips on the mastoid and the 4th and 5th fingers of the same hand on the wing of the sphenoid (anterior temple). Either side will do. **This should make the hip adductors go strong. If so, cranial base compression is likely present.** If the hip adductors do not go strong, somatic dysfunction is probably present elsewhere, (but searching for other sources is beyond the scope of this description).*

*To treat cranial base compression, the physician stands at the head of the table placing his or her thenar eminences on the patient's wings of the sphenoid and his or her 2nd and 3rd fingers on the mastoid processes. **The sphenoid and mastoid processes are then slowly spread apart using a fair amount of force.** The sphenoids go up and the mastoids go down. The treatment is complete when a "melting away" release is felt. The hip abductors are then retested for strength. If the strength of the hip abductors is restored, treatment has been successful.*

Dr Watson warns that other cranial somatic dysfunctions can also cause weakness of the extremities in a similar way and that they require other treatment approaches. However this cranial somatic dysfunction is one of the more common and has the greatest impact on the musculoskeletal system and the patient's health.

My experience is that the "crown of thorns" technique is not a substitute for manual treatment of cranial somatic dysfunction, although it may provide some benefit and can even be used as an adjunct to cranial manipulation. I believe that the technique shown us by Dr Watson is a significant contribution to the methods that the neural therapist has available for optimizing function of the autonomic nervous system.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

The history of neural therapy is intertwined with the history of procaine, whether we date it from Spiess's report of its anti-inflammatory properties in 1906, the Huneke brothers' cure of their sister's migraines in the 1920s, or Franz Huneke's first elicitation of a lightning reaction in 1941. The caine anaesthetics' unique ability to cause lasting improvement long after their anaesthetic effect has worn off has been an endless source of fascination for everyone who has used it in this manner.

Although neural therapists have a natural affection for procaine, (the "**King of medicines**" according to Dosch), procaine hardly belongs to neural therapists alone. Procaine was studied extensively by clinicians in the early 20th century (**Leriche, Ricker, Vishnevski, Speransky and others**) who knew nothing about neural therapy. Drawing on this literature, **Irwin Korr**, the great neurophysiologist of osteopathy, in 1949 challenged the osteopathic procession to look at procaine as a means of extending the reach of manipulative therapy. **Janet Travell's** life work was the identification and study of muscle trigger points. She recognized procaine as an efficient means of "turning off" irritable trigger points. There are doubtless many others who have independently discovered procaine's seemingly magical properties in treating chronic pain.

At the recent Mid-winter neural therapy retreat, **Jeff Harris ND**, alerted us to another application of procaine from "outside" of neural therapy. This is the discovery by the late **Harry Philibert MD** of Louisiana of the "**Infraspinatus Respiratory Reflex**", a trigger point in the infraspinatus muscle closely connected to respiratory difficulty, especially asthma. According to [John L Wilson](#), of a series of 4000 asthmatic patients 85% experienced substantial improvement with treatment of this trigger point with a caine anaesthetic. Treatment can also be helpful in treating other respiratory conditions and shoulder pain.

The trigger point is located medially, close to the medial border of the scapula. A tender nodule should be felt and possibly a narrow band of tight muscle fibres extending from it. Injection is the same as of any other muscle trigger point, directly into the most tender spot. Janet Travell would have recommended stretching of the infraspinatus muscle immediately after the injection, but I am not sure if this was Dr. Philibert's recommendation also.

I was surprised to find no mention of this trigger point in Travell and Simon's classic text "The Trigger Point Manual". Travell described a "**burp button**", a trigger point in the posterior abdominal wall musculature that elicits a loud burp with even light touch! (It is usually found in proper little old ladies. I have seen only a couple of these in my 44 years of practicing medicine.) Travell also described a variety of other somatovisceral trigger points including a cough TP, a hiccup TP and other points creating disturbance in the bladder and



gastrointestinal organs.

On a personal note, this winter for the first time I experienced an attack of **exercise-induced asthma**, while cross country skiing up a steep hill, in very deep snow and in below 0°F (-18°C) temperatures. Needless to say my lungs and shoulder muscles were pushed to the max. I returned home immediately, alarmed by wheezing and shortness of breath, a completely new experience for me. It subsided, but on another cross-country skiing venture a week later, the wheezing returned. I have enjoyed cross-country skiing all my life, so this was bad news indeed.

During the retreat at which Dr. Harris lectured on the Infraspinus Respiratory Reflex, a colleague checked and indeed found a trigger point in my right medial infraspinus muscle. It was treated with a Tenscam device (procaine would no doubt have given the same result). I felt an immediate relaxation of my lungs and have since skied numerous times in this long cold winter, with not a touch of wheezing.

Procaine injections over the chest wall to treat lung disease and lung interference fields are well-established in neural therapy. Descriptions can be found in [my book \(pp.172-173\)](#), in a past newsletter <http://www.neuraltherapybook.com/newsletters/> (Vol.4, No.2, 2009) and in the Dosch manuals. Interestingly Speransky's only publication after his monumental *A Basis for the Theory of Medicine* was a report during the second World War of treating Russian soldiers with pneumonia by injecting blebs of procaine over the upper back (**Speransky AD: Experimental and clinical lobar pneumonia. Am. Rev. Soviet Med. 2:22-27, Oct. 1944**). I do not believe this article can be found on-line, but for those interested I will send a copy as an email attachment on request.

My guess is that neural therapists have unknowingly treated the Infraspinus Respiratory Reflex point many times over the years as part of segmental therapy of the lungs. However Dr. Philibert's discovery offers an elegant and more targeted alternative method of achieving the same result.

The Infraspinus Respiratory Reflex trigger point has been known for over 15 years. I would be interested to know if any neural therapists have been using it and how treatment compares with standard lung segmental therapy.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

"**Sciatica**" (like "allergy" or "arthritis") is one of those so-often **misused semi-medical terms** that has now become close to meaningless. Whenever the word comes up, the physician needs to ask clarifying questions: How was the diagnosis made? Who made it? Where exactly is the pain? etc.

For lay people sciatica simply means pain down the leg. Often the pain is not even down the back of the leg i.e. does not follow sciatic nerve distribution. **Sadly physicians sometimes misuse the term "sciatica" also.** Whether this is due to ignorance or laziness, I cannot say. In any case physicians should probably abandon the word because of the many misunderstandings that surround it. We don't have a special word for describing cervical or thoracic nerve root pain, so why do we need one for the leg?

To be fair, **leg pain caused by nerve root irritation is not always simple to diagnose.** Sciatic nerve irritation is rare and usually caused by piriformis muscle spasm. ([See Volume 1, No. 3 in the newsletter archive.](#)) Irritation of lumbar and sacral nerve roots is more common, but probably much less common than generally believed. One on-line medical dictionary described sciatica as: "*Pain in the lower back and hip radiating down the back of the thigh into the leg, initially attributed to sciatic nerve dysfunction (hence the term), but now known to usually be due to herniated lumbar disk compressing a nerve root, most commonly the L5 or S1 root.*"

I disagree. Orthopaedic physicians with whom I have discussed this subject estimate that only 3 to 5% of patients with leg pain actually have nerve root irritation. The rest have mostly referred pain from ligaments or muscles, or pain related to autonomic nervous system dysfunction (the extreme manifestation being sympathetic dystrophy).

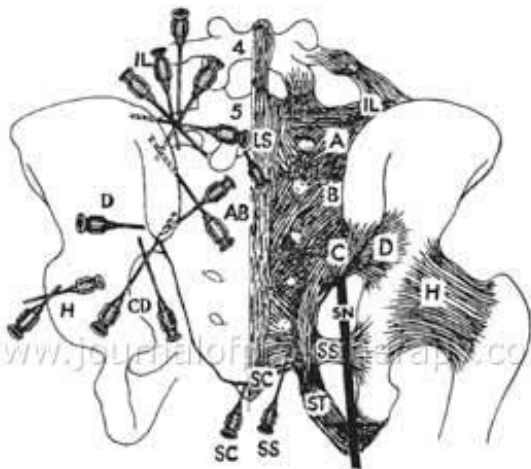
In this short newsletter, I will not attempt to discuss the many methods of diagnosing nerve root irritation, but will rather concentrate on the information that can be obtained from knowledge of referred pain patterns. **There are two "bibles" to consult:** The first is George Hackett's book "**Ligament and Tendon Relaxation (Skeletal Disability): Treated By Prolotherapy**". The second is Travel and Simon's "**Myofascial Pain and Dysfunction: The Trigger Point Manual**".

Hackett's is the more valuable for this differentiation, primarily because of his maps of pain patterns in the legs arising from low back structures, especially the ligaments. He demonstrated that posterior leg pain could be caused by ligament irritation (He believed it to be "laxity".) However **referred pain always "skips" the posterior knee.** When no pain is felt behind the knee, one can be certain that the sciatic nerve or one of its nerve roots is not involved.



The other useful distinction is heel pain. **If pain is felt under the heel, it is referred from a sacrospinus or sacrotuberus ligament.** This is commonly misdiagnosed as "plantar fasciitis". **If the pain "grips" the heel, it is of sciatic nerve origin.**

HACKETT REFERRAL PATTERNS

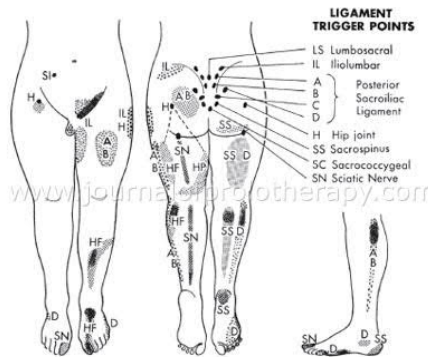


Lower Back and Hip Ligaments

TRIGGER POINTS OF LIGAMENTS

- | | |
|---------------------------------------|--------------------|
| IL: Iliolumbar | ST: Sacrotuberus |
| LS: Lumbosacral—Supra and Interspinus | SC: Sacrococcygeal |
| A, B, C, D: Posterior Sacroiliac | H: Hip—Articular |
| SS: Sacrospinus | SN: Sciatic Nerve |

HACKETT REFERRAL PATTERNS



Pain Referral Patterns

FROM LUMBOSACRAL AND PELVIC JOINT LIGAMENTS

Abbreviation	Ligament	Referral Pattern
IL:	Iliolumbar	Groin, Testicles, Vagina, Inner Thigh
AB:	Posterior Sacroiliac (upper two-thirds)	Buttock, Thigh, Leg (outer surface)
D:	Posterior Sacroiliac (lower outer fibers)	Thigh, Leg (Outer Calf) Foot (Lateral Toes)— Accompanied by Sclatica
HP:	Hip—Pelvic Attachment	Thigh—Posterior & Medial
HF:	Hip—Femoral Attachment	Thigh—Posterior & Lateral
SS:	Sacrospinus & Sacrotuberus	Lower Leg—Anterior & Into the Big Toe & Second Toe Thigh—Posterior Lower Leg—Posterior to the Heel Can Radiate Pain Down the Leg
SN:	Sciatic Nerve	

How does the neural therapist use this information? If the patient has nerve root irritation, **caudal epidural injections** of up to 50 ml procaine ½% can be helpful. No steroid is required. (This technique was discovered independently of the neural therapy world by the British orthopaedic physician James Cyriax in the 1950s.)

If the pain is not of nerve or nerve root origin, the usual search for interference fields and/or somatic dysfunction should be undertaken. This is where at least some knowledge of both neural therapy and osteopathy (or other systems of biomechanics) can be so useful. **It is not unusual to find both mechanical and non-mechanical interference fields contributing to a leg pain syndrome.** Here is an example:

A 49-year-old man presented with right leg pain of three week's duration. The pain did not follow any pattern suggesting nerve irritation and was associated with low back stiffness. The pain had begun soon after a yoga session where he felt he had strained himself performing a back extension exercise while lying prone. He also felt at the time mild discomfort in the region of a left inguinal hernia surgical scar, where he had undergone surgery a few months before.

On examination, there was mild hamstring tightness on the right side. While lying supine the pelvis was asymmetric with the right innominate rotated anteriorly. While prone, the sacrum



was rotated anteriorly on a left oblique axis. Paraspinal muscle tension could be felt on the right side of the lumbar spine.

Autonomic response testing detected an interference field in the left inguinal scar. This was treated with the Tenscam device. (Infiltration with dilute procaine would have been an equally effective alternative.) There was an immediate restoration of pelvic symmetry and muscle balance and the leg pain resolved.

It is time for physicians to discard the word "sciatica", and learn to diagnose leg pain properly. Proper diagnosis leads to correct treatment. Should we be satisfied with less?

Introductory Neural therapy workshop

Jeff Harris ND is teaching a Neural Therapy Workshop in **Halifax, Nova Scotia on September 22, 23 and 24th of 2014**. If you are interested in this workshop or others he is teaching you can go to the workshop page of his website: www.jeffharrisnd.com

Volunteers are needed to organize an educational conference on neural therapy in 2015. The organizing committee would design an educational program, choose a location, and get the word out! Especially valuable would be those connected to a university or other organization that could provide CME credits. So if you would like to take part in an interesting project, please contact either Michael Gurevich MD or Robert Kidd MD,CM.

And for those who have not already done so, if you are interested in being part of a neural therapy organization, please email one of the below with your contact info:

- Michael Gurevich MD MIGurevich@gmail.com Long Island, NY, or
 - Gerald Harris DO zymex61@yahoo.com Fort Worth, Texas, or
 - Jeff Harris ND drjrharris@gmail.com Seattle, WA, or
 - Robert Kidd MD, CM rfkidd@rfkidd.com Renfrew, ON, Canada
-

The 6th World Biennial Conference on Neural Therapy was held in Ecuador on March 20-23rd. Carlos Chiriboga reports on some highlights:

1. **Human Photosynthesis** (Dr. Arturo Solis from Mexico) An ophthalmologist using melatonin for treatment of various diseases.
2. **Superior Cervical Ganglion** (Dr. Hans Peyer from Switzerland) Treatment of psychological conditions with procaine infiltration of the ganglion.
3. **Neural therapy and structured water** (Dr. Gerald Pollack from the USA) Structured water's function in the matrix and in connection with various diseases.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of Neural Therapy: Applied Neurophysiology and Other Topics

Dear Colleagues:

A newsletter reader has kindly sent me a long-lost **paper by the great Russian neurophysiologist, AD Speransky**, entitled "Past traumatic contractures". This paper was published in 1944 and had escaped my notice despite many years of searching for more information by and about this remarkable man.

As reader regular readers of this newsletter know, I refer to Speransky frequently and consider knowledge of his theories to be essential to understanding how neural therapy works. However access to his work is complicated by language barriers (publications in French, Russian and English) and the political, economic and military turmoil in Russia during the 1930s and 1940s.

When I asked my correspondent, **Steve Walton DC**, how he had found this article, his answer was this:

I was at one time Chairman of the Principles and Practice Department of Cleveland Chiropractic College, Los Angeles. I had the good fortune to have an extremely intelligent and skilled mentor, Dr. RJ Watkins (first Clinic Director at Canadian Memorial Chiropractic College).

He turned me on to Speransky, and that led me into the bowels of the UCLA BioMed Library where I went through the entire Index Medicus at the time (1983) to see if I could find some refutation of Speransky and his theories: I couldn't... every article I could find (there weren't that many) referred to him as an authority.

I left LA in 1985 and moved to Hawaii. I brought my library and file cabinet with me. That's where I found the article, sitting forgotten (by me) for almost 30 years.

It is amazingly on point for those in our professions. If I read it right, then relatively brief periods of adaptation to trauma leave a permanent trace in the neural circuitry. These traces may produce atypical responses when the system is under stress. (The importance of a good history.) Also, it gives a good rationale for treating the "good side" when approaching extremities. Not shocking when we think about how "mirror-box" therapy resolves phantom limb issues, though.

I've been incorporating neurofeedback into my practice, and it seems that all of us who address the role of the nervous system in health/disease wrestle with the same issues. So, I enjoy reading your thoughts from the neural therapy point of view. Anyway, I'm glad you enjoyed the article, and thanks for sharing your insights online. Steve



So here is the article published in **American Review of Soviet Medicine, Oct. 1946, Vol IV. #1:**

POSTTRAUMATIC CONTRACTURES

A. D. SPERANSKI

Studies were undertaken on the nature of posttraumatic contractures. The neural or reflex origin of contractures has been taken for granted since the reflex character of posttraumatic contractures has been proved by careful clinical experiments of Molotkov, Novotelnov, Leriche, and Shamov. The source of the pathologic reflex contracture may lie in the sympathetic or spinal nerves. An analysis of the available literature suggests that both points of view are probably correct. Some posttraumatic contractures are not the result of scars, and finally, others occur after superficial soft tissue wounds without injury to large nerves. These are called "hysterical" contractures. They may also occur after protracted immobilization, especially in plaster casts. In the first case, deep irritation is apparently absent; in the second, the local disturbances follow pressure and irritation from interrupted circulation in tendons, muscles, and joints.

Work was carried on for several years on dystrophic processes in the nervous system produced by various methods. New facts have been gathered by S. I. Frankshtein in the prewar period. The study was based on the Sherrington pattern of "decerebrate rigidity." The cat was used because decerebrate rigidity is pronounced in this animal. The animal was anesthetized, skull trephined, carotids ligated, and blunt separation of the brain done in the region of the tentorium. Such interference produces contracture of an extensor type due to disturbance of normal tonicity. This may last hours and days. The whole phenomenon is attributed to irritation of the "red nucleus" (Sherrington, Magnus), or its removal (Beritov).

Both central and peripheral irritation was investigated in order to ascertain in what manner extensor rigidity was intensified after external influences. It was noted that the side on which the animal lies is always under greater tension than the opposite. We investigated other forms of peripheral irritation likewise related to the proprioceptor but of a more specialized character. A local inflammatory process might be such an irritation.

Experimental procedure: 1-2 drops of turpentine was injected subcutaneously on the posterior surface of one paw. An abscess developed and within 3-5 days the cat "favored" the injured paw and walked on three legs. The abscess sometimes reached considerable size and ulcerated.

After decerebration, the body and extremities were affected with extensor rigidity with the exception of the injured part. The affected paw either remained soft and pliable in all its joints or developed flexor rigidity. Prolonged observation revealed an intermittent relaxation of spasticity, not only in the affected paw but in the homolateral one. This can be explained only by the fact that the irritation spreading through the nervous system is of a reciprocal character. A peripheral inflammatory process, therefore, involves the neural segments. This involvement occurs also in decerebration when a conscious "protective" reflex is nonexistent.



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For neural therapy and advanced healing



The unconscious "protective" reflex as seen in a decapitated frog was studied in the following experiment. Cats were given subcutaneous turpentine injections in the front or hind paws. Decerebration was postponed until the abscess healed and the functions of the extremity restored. After decerebration, rigidity developed in all parts of the body with the exception of the paw that had recently been inflamed.

The following case is characteristic. Decerebration was performed on a normal cat but for some unexplained reason, decerebrate rigidity did not affect one of the hind legs. It remained flaccid during the whole experiment. When the cat died postmortem examination revealed an old healed fracture of the corresponding hip.

It may be assumed that peripheral trauma or inflammation produces irritation of the nervous system which in turn acts as a source of further irritation. This source of nervous irritability is always manifest in the intact animal because the unusual mobility of the nervous system favors rapid compensation for any functional disturbance. In other words, the animal becomes functionally compensated sooner than the complete healing of the injury.

This concept was demonstrated experimentally many years ago but met with strong objections. Surgeons pointed out that in operations on various parts of the body and for various injuries they had not observed focal disturbances in the nervous system. It seems that were it not for the compensating capacity which a complex organism possesses, thanks to its nervous system, contemporary surgery would hardly be possible.

In other experiments, mechanical pressure was produced by a plaster of paris bandage, applied for 3-8 days. After removal of the plaster cast the cat was decerebrated. The results were the same as in the first series of experiments. Extensor decerebrate rigidity occurred in the body and extremities but not in the one that had been immobilized by the plaster. A modification of the experiments consisted in applying the plaster to a flexed or extended leg. The bandage was removed in 8-5 days. The cat quickly began to walk and ran normally making equal use of all legs. Decerebration at this point produced rigidity similar to the pattern following inflammation. It appears that brief plaster immobilization involves not only local tissue disturbance but a permanent change in the corresponding parts of the nervous system.

A "protective" reaction was not formed because the animal had recovered its functions before the experiment. It is only possible to assume an after effect of irritation and to speak of the changes in the nervous system as a result of inadequate proprioceptive irritation.

The experiments show that there was a change in the nervous system, developing progressively from the periphery. The effect on the nervous system is either dissipated with varying rapidity or persists depending on the duration and degree of intensity of the irritation.

Similar experiments were then done on dogs. This was undertaken to analyze the capacity of the nervous system for compensatory activity as worked out by Anokhin and Asratyan. Inflammation was produced by 2-3 drops of turpentine injected under the skin of the front or hind paw posteriorly. In a very short time the dog drew in the paw and moved about on three legs. When another injury was inflicted on the animal in the same region of the opposite paw, the animal almost immediately began to use all four extremities freely, without



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limping. This occurred in several cases where repeated symmetrical irritation produced less effect than the previous unilateral injury.

It appears that the so-called protective reaction does not play any role. Corroboration was obtained by the following experiments. A plaster of paris bandage was applied to a cat in an extended position, not only on one, but on both front legs. After five days the bandage was removed and the animal was decerebrated. Decerebrate rigidity was uniform but extensor rigidity of the front legs alternated with flexor rigidity.

Similar clinical and experimental observations were known but no explanation offered. Trendelenburg noted that motor disorders in dogs after decortication disappeared rapidly if a bilateral operation were done on the brain. P. K. Anolchin noted the same phenomenon after bilateral section of the posterior radicles. A. Kharitonov observed a more rapid recovery of functions in animals when total rather than partial removal of the cerebellum was done. Finally, Gubich observed that motor functions are restored more readily in a dog when bilateral cutting of the sciatic nerves was performed instead of unilateral. These facts become clear when it is realized that neural processes are interwoven and interacting and occur to a marked degree in the same or neighboring segments.

Conclusions and suggestions: Incipient "reflex" contractures or other affections such as causalgia lacking clearly defined organic changes should be counterirritation in a symmetrical part of the body. This stimulation may be the quartz lamp, roentgen rays, mustard poultice, cantharidin or, as recommended by Davidenkov, novocaine. Probably different combinations are called for in various cases. This treatment does not hold any danger for the patient.

Voprosy neirokhirurgii 1944,
Vol. 8, No. 3, pp. 3-7

Much to think about from this paper!

[Neural Therapy Basic Workshop](#)

Halifax, NS, Canada, September 22, 23 & 24, 2014.
By Jeff Harris, ND

[Neural Therapy Advanced Workshop](#)

Seattle, WA October 10, 11 & 12, 2014
By Jeff Harris ND

[Neural Therapy Basic Workshop](#)

Seattle, WA October 17, 18 & 19, 2014
By Jeff Harris ND



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-----**More Letters:**

Dear Robert

I absolutely agree about sciatica and that Hackett and Travell and Simons are essential to treating leg pain. There is another type of leg pain due to irritated cutaneous nerves, often irritated as they emerge from fascia eg the cluneal nerves over the top of the iliac crests (I'd never hear of them either but they are there in Google images if you want to have a look) and the lateral femoral cutaneous nerves, and sural and saphenous nerves. This is a true neuropathy with burning pain mediated by the capsaicin sensitive nerves, and the nerves are tender to palpate, in fact it makes the patient gasp, unlike referred pain which is not tender to palpation. The doctor who pioneered this is John Lyftogt from NZ and his workshops are amazing - full of fascinating research and demonstrations - teaching simple 1cc injections of 5% glucose, no lignocaine! Think of all those patients with lateral hip pain that is worse when they lie on it at night. Some of it is of course glut minimus trigger point referral pain, but not the ones where the tenderness goes all down the lateral thigh. One of the doctors who did his first workshop with me in 2009, has done a randomised trial of the use of 5% glucose in caudal epidurals - much better than steroid. See his website <http://www.doctorliftoff.co.nz/> I think you'll be fascinated. I can cure lots more pain using all 3 approaches now.

Cheers

Margaret Taylor MD
Urrbrae
Australia

Dear Dr Kidd;

I enjoyed your article so much. I just wanted to share my humble experience in that matter. I worked for 10 years at the VA system and I had the privilege to do enormous amounts of SI prolotherapy and PRP under X ray guidance. Surprisingly around 5 % of these patients did not respond to prolo therapy and I send them for EMG and almost everybody had S1 Radiculopathy. The genius Dr Cyriax had discovered this long time ago and he mentioned that main differential diagnosis of SI pain is S1 Radiculopathy .

Hope this was helpful and thank you again for your wonderful contribution in the field of neural therapy.

Ayman Abdel-Halim
Little Rock AR
USA



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Robert,

Very interesting!!!! And I absolutely agree.

Some patients like to hear they have sciatic problems. It is difficult to explain to them that some leg pains are not sciatic pain.

Very common interference field are tonsils or very close areas.

Best regards,

Carlos Chiroboga
Guayaquil,
Ecuador



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

Some North Americans who learned neural therapy from **Dietrich Klinghardt** in the mid-1990s will remember **Louisa Williams**. She is a gifted naturopath-chiropractor who (with Dr. Klinghardt) **discovered that Applied Kinesiology (AK) could be used to detect interference fields**. They developed a system based on AK that they called **Autonomic Response Testing or ART**. To this day, most North American neural therapists use ART in diagnosis of interference fields and we can thank Louisa Williams and Dietrich Klinghardt for this discovery.

William's creativity did not end with ART. In 2007, she published an important textbook called "**Radical Medicine**". This 1139 page-long work was a massive undertaking bringing together homeopathy, heavy metal and other toxicology, nutrition, food allergies, dysbiosis, neural therapy, homeopathy (and vaccinations) and dental and other musculoskeletal dysfunction. This is an impressive tome for both its depth and breadth of knowledge. And it is a truly radical challenge to many of the too-little-examined beliefs of conventional medicine.

Louisa Williams has now published another book: "**The 5 Post Cavitation Surgery Days**". It is a much smaller one (only 80 pages) and **is written for patients (and their dentists and/or physicians)** who are facing the problem of what to do with problem teeth. No-one wants to part with a tooth unnecessarily, yet the risks of retaining a sick tooth may be high. And it is important that removing a toxic tooth be done in such a way that the patient is left healthier than before the procedure. This is a difficult subject requiring not only good clinical judgement, but also the patient's participation in decision-making. The patient needs to understand this (if only for medico-legal reasons) before any treatment is undertaken.

The first half of the book is about dental foci: their importance systemically, how to diagnose them, and the place of conservative vs. surgical treatment. Despite the somewhat misleading title of Chapter 2, ("Dental Focal Infections"), foci may include non-infectious, (e.g. dental galvanism and traumatic malocclusion), as well as infectious (impacted teeth, failed root canals, etc.) foci. This concept is an important one for patients to understand as the idea that a silent, yet troublesome tooth may be causing remote symptoms is a difficult one for many to grasp.

The next section about diagnosis is primarily for the physician and/or dentist. However the importance of patient involvement in the diagnostic process is again stressed. Symptom patterns, dental X-rays, ultrasound, energetic testing and therapeutic trials are all discussed.

Dr. Williams' list of non-surgical treatments of dental foci leans heavily on homeopathics (both acute and constitutional) and isopathics (Sanum remedies). She acknowledges the



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value of neural therapy, but avoids caine anaesthetic injections because of their potential carcinogenicity. Instead she relies on a laser in conjunction with homeopathic drops. Her favourite laser is the "[Canadian](#)" laser made by Jarek Manufacturing (100mw infra red).

The second half of the book is about surgical treatment: preparation, technique, and after-care. One chapter is about choosing a surgeon and the pros and cons of ancillary techniques, such as bone grafting, collagen plugs, platelet rich fibrin, and the use of low-dose epinephrine.

The section on pre- and post- cavitation surgery has many practical tips on supporting the patient undergoing surgery. Dr. Williams feels that the 5 Post Cavitation Surgery Days are the critical ones, hence the title of the book. Much of the patient support is from homeopathics, detoxification products and diet. **Of interest to neural therapists will be the attention paid to the autonomic ganglia involved in regulating the periodontal, face and neck tissues.** Neural therapy certainly can play a role in optimizing healing, whether classical techniques with caine anaesthetics or energetic devices are used.

This book will be of value to two classes of readers:

1. **for patients** who want to understand how remote symptoms can be caused by dental problems and how teeth should subsequently be treated.
2. **for physician/dentists** who want a concise description of dental foci, their implications and their treatment.

This book is written very much from a naturopathic-homeopathic perspective and the recommended treatments may be intimidating to some. Nevertheless **it has much to offer neural therapists who sooner or later must deal with dental problems and all the decisions that come with them.**

The book can be obtained in electronic form from <http://www.radicalmedicine.com>. For a paper version, Dr. Williams suggests downloading and taking the file to Office Depot or Staples for printing and binding.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

This month's topic is **kidneys as interference fields**. Kidneys are hardy organs; they seem to tolerate the stresses of modern life quite well and are easily overlooked in the search for interference fields. Part of the reason is that they seldom express pain and do not usually declare serious trouble until renal failure is looming.

Renal failure is the 12th leading cause of death in the world (9th in the US). Diabetes and hypertension are the most common underlying causes. Yet, **stress on the kidneys can manifest even in those who are not seemingly at risk, and can be quite subtle**. The neural therapist can detect these stresses through energetic testing and neural therapy can play an important part in resolving them.

Although kidneys are best understood as excretory organs, they have two other functions that may signal stress when compromised. One is **regulating blood pressure**. The other is **regulating water and minerals in the extracellular space**.

Essential (or idiopathic) hypertension is said to account for 90 to 95% of cases of high blood pressure. Personally, I dispute that figure because I have seen many patients with "essential" hypertension respond to improvement in diet, (including removal of sensitizing foods), exercise, weight loss, supplemental magnesium, vitamin D and last (but not least) treating periodontal infection, amalgam removal and mercury detoxification. This last factor is one that not uncommonly can be found by searching for kidney interference fields. (Amalgam in the mouth does not necessarily cause hypertension; but if kidney interference fields are found and autonomic response testing indicates mercury to be a stressor, the case for a causal relationship becomes strong.) Of course, treatment requires more than just neural therapy of the kidney(s), but also a comprehensive detoxification plan.

I have had the privilege of treating a number of **biological dentists** over the years and hypertension is a common problem. Even though they may not be placing amalgam fillings, the exposure to mercury from removal of old amalgam puts them at risk and hypertension is not uncommonly the result. In my opinion all biological dentists should be checked regularly for signs of mercury poisoning, for the sake of their kidneys, if nothing else.

The second common "red flag" for kidney stress is fluid retention. This is a generalized "puffiness" involving the whole body, different from the dependent oedema of congestive heart failure and the cyclical fluid retention associated with the menstrual cycle. This can occur long before the renal failure of nephrotic syndrome and is often associated with kidney interference fields.

So where do kidney interference fields come from? In some cases a history can be obtained of past pyelonephritis, renal stones and/or obstruction. Far more common, in my



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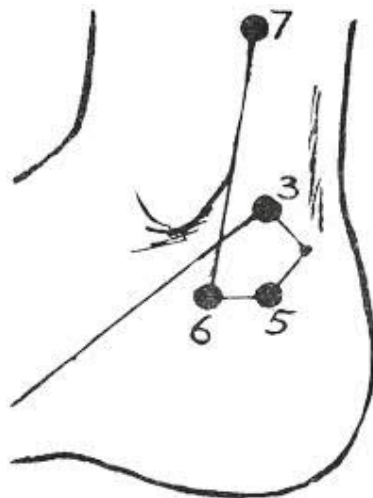


experience, is current stress from mercury. The kidneys [retain more mercury](#) than any other major organ in the body*. Renal failure from mercury appears to be rare, but in my opinion is likely [under-diagnosed](#). I have seen two cases of nephrotic syndrome related to mercury (both of which were missed by the nephrologist). In one, amalgam removal and detoxification of mercury resulted in a permanent cure.

Typically symptoms begin after dental work involving amalgam, either placement or removal of old fillings. One or both kidneys can be identified as interference fields and neural therapy results in an immediate response - diuresis and reduction of tissue fluid retention. Although relief is obtained, treatment should not stop with neural therapy. If amalgam is still present in the oral cavity, it should be removed and a detoxification program initiated.

A third (**uncommon**) **red flag for renal stress** is presented in this recent case from my own practice:

*A healthy 65-year old woman presented with **bilateral swelling of her lateral ankles in the space just below the lateral malleoli**, of several months duration. There was no immediately preceding history of trauma or strain, but over a lifetime she had experienced a number of ankle sprains and injuries to the forefeet and distal calves. Physical examination of the feet, ankles, legs and pelvis revealed only minor somatic dysfunction and osteopathic manipulation resulted in no change in the swelling. **What made this case unusual was that the swelling was bilateral and involved the same space (below the lateral malleoli) in each foot.** Because **this space contains three kidney acupuncture spots**, the kidneys were checked for interference fields by autonomic response testing. Sure enough, touching the left kidney caused indicator muscle weakening, which could be reversed with the presence of mercury. It was at this point that the patient volunteered that she had had a large amalgam filling placed (almost a complete crown) a few months before.*



All three of these examples of kidney interference fields were triggered by the stress of mercury. No doubt there are many other causes, (not least nephrotoxic medications), but the close connection of teeth to the practice of neural therapy and the (alas) still common usage



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of dental amalgam should raise awareness of kidneys as potential interference fields.

According to an unreferenced statement in <http://www.arltma.com/Articles/MercuryToxDoc.htm> "in postmortem samples from mercury mine workers in Yugoslavia, the highest concentration of mercury was found in the thyroid and pituitary glands, suggesting that retention may be higher in these organs than in the kidneys."



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Volume 9, No. 10, Oct. 2014

NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

David Vinyes, of Barcelona, Spain, is president of the Spanish Neural Therapy Society and a very busy man. Not only is he in demand as a speaker internationally, but he also is active in neural therapy education in Spain, is an organizer of international neural therapy conferences and is editor of a Spanish language neural therapy newsletter, available through <http://www.terapianeural.com>.

So it is not surprising that he sometimes gets a little behind in his reading. I know this from his **recent letter in response to my newsletter of last April on the [Infraspinatus Respiratory Reflex](#)** (Vol. 9, No. 4):

*Dear Robert,
Hello again... I'm on holidays and I'm reading your interesting newsletters... thanks for sending them!
When I do lung segmental therapy I palpate the whole area, ventral and dorsal, looking for tender nodules or narrow bands of tight muscle fibers; you can find them in the subdiaphragmatic area, trapezius, pectoralis and of course along the paradorsal and parascapular areas. Several times I have seen a similar reaction to the one you describe with the IRR, when injecting the subdiaphragmatic points, probably when there is a major component of anxiety... often you can see how the lungs open immediately with a sigh. I'd like you to send me the Speransky article about pneumonia... I didn't know about that!
Thanks!!!*

Then soon after came another note:

*Dear Robert,
Thanks for this very valuable Speransky article; I didn't know about that and we'll deliver it to the students of the course along with his book that was translated into Spanish in 1954. I don't know if you have the articles I'm sending to you... Research like this is a hope for us. I think that in the near future, conventional medicine will discover the importance of the ANS and neural therapy.*

Dr Vinyes has sent us three articles, a recent one by **Stefan Weinschenk** entitled "[Neural therapy - a review of the therapeutic uses of local anesthetics](#)". Dr Weinschenk is the author of "**Handbuch Neuraltherapie**", a premier German neural therapy textbook. ([See newsletter archive Vol. 8, no. 9](#)). He is an academic and writes in a way that will satisfy the highest scholarly standards. However his target audience is likely unfamiliar with neural therapy, so some of the material will already be common knowledge for readers of this newsletter. Nevertheless **there are clinical pearls to be found here**, and the review is recommended reading for any neural therapy practitioner.



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The second article, "[The Inflammatory reflex](#)" (also a review) was published by Kevin Tracey in 2002. Its subject is the research that demonstrates the inhibitory effect of the autonomic nervous system on inflammation. This is old news to neural therapists familiar with the clinical literature of the first half of the 20th century, and also to older physicians who trained in the days when vagotomy was a treatment for peptic ulcer. However **this modern perspective looks at the subject from a different angle, namely the biochemistry and cellular physiology creating the nervous system effects.** Central to this process is the discovery that **cholinergic activity inhibits the macrophages' release of inflammatory cytokines.** Then a sensory feedback loop to the hypothalamus allows for precise nervous system control of the inflammatory process.

This is a readable and interesting article and I can see why Dr Vinyes uses this in his neural therapy teaching. For those who want to pursue this subject further, Tracey has since written more papers in a similar vein, [one of them](#) including the possible role of "complementary and alternative therapies".

The third paper is a classic from 1938 by A.A. Vishnevsky called "[Novocaine blockade in the treatment of gangrene](#)". This well-written and well-translated article immerses us into a long-gone world - that of leprosy in the pre-antibiotic era. Leprosy was a horrible disease, but **because of its chronicity and its superficial manifestations lent itself to test Speransky's theories** (Vol. 7, No. 1) about the nervous system's place in the pathophysiology of infectious (and other) diseases.

The disease itself exhibits characteristics suggesting nervous system involvement in its spread; **skin and neuropathic lesions are often symmetric**, a difficult phenomenon to explain by haematogenous spread of bacteria. Also mycobacterium leprae appears to be of **low pathogenicity**. Individuals can carry m. leprae for decades without contracting the disease. Disease usually manifests only with some irritation of the system, e.g. a cold or other infection, or trauma.

The paper describes numerous cases responding to injections of Novocaine (procaine) into areas remote from the leprosy lesions. At times regional blocks were performed, but more commonly large volumes of dilute procaine were injected into the para-renal space. **Vishnevsky's feeling was that he was creating a "weak irritation" that changed the trophic status of the whole nervous system.** (Speransky proposed that weak irritation of the nervous system could trigger both trophic and/or dystrophic effects.)

The whole paper is worth reading, but if time is short, scroll down to the Discussion for an excellent summary of the rationale for this method of treating leprosy, or any infectious disease.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

Last month's newsletter included three English-language articles on neural therapy. I hope you found time to read them or at least place them on your desktop to be read later. This month I intend to get back to the usual format of **something short and quick that can be easily applied to medical practice**. The subject? - **a painful big toe**.

I suppose the first thing that comes to mind when a patient presents with a painful big toe is **gout** - that is, assuming there is no history of trauma. When the gouty attack is full-blown, diagnosis is usually simple - a red, painful, exquisitely sensitive toe, with pain exacerbated by active or passive joint movement. When less acute, diagnosis can be problematic, as the pattern is similar to any other form of toe arthritis. An elevated serum uric acid usually makes the situation clear.

If the onset of pain was preceded by trauma, **traumatic arthritis, subungual hematoma, ligament strain or fractures** need to be ruled out. All of these will display local symptoms and signs when examined carefully.

Where diagnosis becomes more challenging is **when minimal signs of tenderness, swelling or pain on movement are present**. Then we must start thinking about referred pain. (Some tenderness may be present with referred pain.)

Elementary neuroanatomy tells us that **irritation of a L5 nerve root** can cause pain in a first toe, although it is usually accompanied by pain down the posterior leg.

An uncommon cause of first toe pain is pain referred from the liver through the corresponding acupuncture meridian. **The liver meridian** extends down to the lateral side of the first toe. One method of diagnosing is checking the liver by autonomic response testing. Treatment may be neural therapy of the liver.

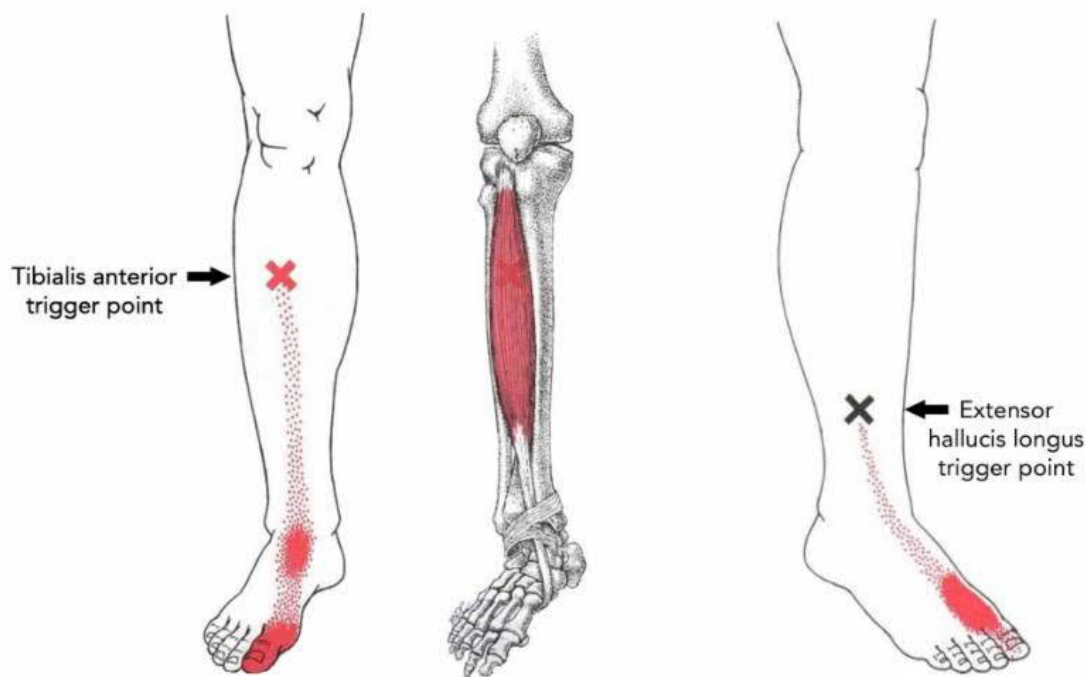
Pain can also be referred from musculoskeletal structures. A quick check of Hackett's map of referred pain from low back ligaments shows no referral of pain to the first toe. **However pain can be referred to the first toe from hip ligaments.**

And then there are muscles, in particular, their trigger points. I personally have been unable to memorize all the pain referral patterns from muscle trigger points, so I depend on Travell and Simon's 2-volume "**Myofascial pain and dysfunction: The trigger point manual**". Not only are these books well written and well illustrated but also the organization is superb.

The first volume is about the upper part of the body, the second the lower. In the inside of the front cover is a list of the muscles in the volume and on the facing page a guide to where they can be found. In the case of toe pain, we are quickly directed (in the second book) to



Chapter 18 where one finds that **great toe pain can be referred from three different muscles: the tibialis anterior, the extensor hallucis longus and the flexor hallucis brevis**. Each pattern is somewhat different, e.g. the tibialis anterior trigger point (TP) also refers to the anterior ankle. The extensor hallucis longus referral pattern does not include the anterior ankle, but centers more on the dorsal aspect of proximal first toe.



Examination including muscle strength can give clues, but ultimately the TP has to be found in the muscle. When it is found **an injection of procaine 1/2% into the TP combined with stretching the muscle** can give relief from the toe pain. Alternatively, the Travell "spray and stretch" technique can be used or the TP can be treated directly with an energetic device such as the Tenscam.

The patient who reminded me of this was an otherwise healthy 70-year old man who presented with pain over the proximal first toe. He gave no history of trauma or strain. He felt it most while walking, especially during the weight-bearing phase of gait. A trigger point was detected distal to the junction of the medial and lower thirds of the lower leg, anterior to the fibula.

Travel and Simons always give advice about "**perpetuating factors**", those conditions that give rise to TPs in the first place. To these, the neural therapist can add the possibility of **other interference fields** and the osteopath can search for **somatic dysfunction**. In the patient mentioned above, a tight piriformis muscle was present, probably related to chronic sacroiliac instability.

In the case of toe pain from tibialis anterior or extensor hallucis longus trigger points, the leg and pelvis should be searched for interference fields in scars, in old bone contusions, in injection sites and in the L3 sympathetic ganglion.



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For neural therapy and advanced healing



Identification and treatment of trigger points is an important part of neural therapy and often helps solve difficult-to diagnose pain problems. But the neural therapist should not stop at simply treating the TP. **The factors that created the TP should be addressed as well as associated interference fields.**



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

This month I would like to discuss **anusitis**, a common problem, but one that patients often neglect to mention unless symptoms are severe. For some reason "heartburn", "sore throat", and "indigestion" seem to be worthy of attention, but pain or itching of the anus? - not so much.

The anus is a common interference field and should always be checked for with pain in the low back or the lower extremities, especially when bilateral. A history of haemorrhoids, anal fissure, (even if asymptomatic) or any other illness or injury of the anus should raise suspicion that an interference field is present.

However this month **I do not intend to discuss the anus as an interference field but rather inflammation of the anus** - which can be an interference field, but which deserves treatment in its own right. Bleeding may be present (usually only on the toilet paper), itching, a clear discharge, or pain.

A digital rectal exam (and occasionally a proctoscopic examination) should be performed to **rule out anal fissure, perianal abscess, malignancy, etc.** A stool examination for parasites may be necessary if the main symptom is itching. Once the diagnosis of anusitis is made, neural therapy can be attempted. (The classical technique is described on page 60 of my book [Neural therapy: Applied neurophysiology and other topics](#)). Unfortunately even if there is a response, the symptoms will likely recur if the conditions that brought on the anusitis persist. So what might these conditions be?

The anus is part of the gastrointestinal (GI) tract and its function follows similar rules, as do other parts of the tract. Speransky's animal experiments demonstrated that certain areas of the GI tract were much **more sensitive to irritation** than other parts - namely the **gastro-duodenal junction, the ileo-caecal junction and the rectum.**

The most direct form of irritation is the intestinal contents, i.e. the food we eat. And as it turns out **anusitis almost always is exacerbated by certain foods.** Elimination-challenge diets will often clarify this, but sometimes serum IgG or faecal IgA analysis for food antigens (delayed food sensitivity testing) can be helpful. This is particularly true if the anus is reacting to a variety of foods.

(Allergists generally discount food sensitivity testing because of the number of false positives and false negatives. However as long as these limitations are taken into account, the results can still be helpful. The best policy is to test the lab results by sequential elimination-challenges of the suspect foods.)

Most cases of anusitis will improve by elimination of the offending foods. However some



Toxic Metals; Urine

TOXIC METALS					
		RESULT µg/g creat	REFERENCE INTERVAL	WITHIN REFERENCE	OUTSIDE REFERENCE
Aluminum	(Al)	1.8	< 35		
Antimony	(Sb)	0.2	< 0.2		
Arsenic	(As)	34	< 80		
Barium	(Ba)	6.3	< 7		
Beryllium	(Be)	< dl	< 1		
Bismuth	(Bi)	1.1	< 4		
Cadmium	(Cd)	0.4	< 1		
Cesium	(Cs)	8.4	< 10		
Gadolinium	(Gd)	< dl	< 0.8		
Lead	(Pb)	17	< 2		
Mercury	(Hg)	19	< 4		
Nickel	(Ni)	3.7	< 10		
Palladium	(Pd)	< dl	< 0.15		
Platinum	(Pt)	< dl	< 0.1		
Tellurium	(Te)	< dl	< 0.5		
Thallium	(Tl)	0.4	< 0.5		
Thorium	(Th)	< dl	< 0.03		
Tin	(Sn)	5.2	< 5		
Tungsten	(W)	< dl	< 0.4		
Uranium	(U)	< dl	< 0.04		

URINE CREATININE							
	RESULT mg/dL	REFERENCE INTERVAL	-2SD	-1SD	MEAN	+1SD	+2SD
Creatinine	68.2	40- 225					

will persist. In that case, **the general health of the GI system needs to be assessed.** Hypochlorhydria, parasites, intestinal dysbiosis and other forms of dysfunction need to be ruled out and/or treated.

However a recent case reminded me of the importance of **systemic factors** whenever inflammation persists.

A 63-year old woman presented with painful anusitis and bleeding. Neural therapy gave temporary relief, and food sensitivity testing and elimination of offending foods quieted her symptoms somewhat. Attention was paid to diet, digestion and correcting dysbiosis. However she continued to have relapses, especially when under stress.

*During a particularly painful period, **the interference field at the anus was challenged by autonomic response testing with mercury and DMPS.** (Twenty years previously the patient had a debilitating facial pain syndrome, which was cured over a period of several years by amalgam removal, dental reconstruction and mercury detoxification.) A clear response was obtained so the patient was given an **intravenous bolus of 250 mg DMPS** in addition to the usual neural therapy of the anus.*

*The patient this time had **a clear-cut remission of her anal bleeding and pain** for well over a month. A 6-hour urine collection after the DMPS demonstrated 19mcg mercury /g creatinine and 17mcg lead /g creatinine. (The lead exposure had come from living in a house during*



renovations some years before.) A second similar treatment gave another month of relief. Most teachers of neural therapy warn their students that **if several interference fields are found in one session, that the presence of a neurotoxin should be considered.** Toxic metals are among the most common. **This principle is also true in the presence of inflammation,** whether systemic as with arthritis, or local as with anusitis. In either case detoxification should be instituted.

I find it interesting the physicians who treat Lyme disease have come to a similar conclusion: that toxic metals need to be removed if systemic inflammation is to be controlled.

Toxic metals and inflammation have a two-way relationship. **Toxic metals tend to deposit in areas of inflammation** (as in my patient with anusitis). **Inflammation also impairs the body's natural ability to detoxify toxic metals.** So when inflammation is present, the body's impaired detoxification capacity needs to be assisted in order to reduce the inflammation.

Getting back to anusitis: neural therapy is a useful treatment for anusitis but generally requires treatment of perpetuating factors for lasting success.

Letters from readers:

5 years ago I had a 65 y/o patient with a painful big toe. X rays showed Hallux rigidus. I treated the TP with good results, but the main interference field of this patient was the liver. I discovered he had a liver cancer. I absolutely agree with you, liver should be kept in mind with this kind of pain when trauma has been ruled out.

Carlos Chiriboga,
Ecuador

Excellent reminder of Dr. Travel's work.

Nothing happens by accident and a long time patient came in just a few days after I received this newsletter with exactly this problem.

Trigger point was in the tibialis anterior muscle. and injection with prolozone to this area resolved his painful big toe. There was no interference field of the liver.

He has had a new job for the past several months as a driver and the relatively new use of his right foot in driving much more that he had likely resulted in his symptoms. When his family physician noted normal uric acid levels, there was noting else she could offer other than NSAIDS which he did not want to take.

Thanks again for a reminder to "dust off" this two volume set of books from my shelf!

Rob Banner
Canada



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As usual an excellent article. I didn't know the one about the meridian projection to the first toe.

Another one to add is vascular problems - not just peripheral vascular disease but also arterial thrombembolism that may occur at any age. Depending on the degree of stenosis, symptoms can be rather varied; the toe affected may just be "the last meadow". Amazingly enough it is possible to walk about without claudication with a stenosis of $> 80\%$ of the common femoral artery.

Regards,

Rainer Kumm
Germany



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

This month I would like to discuss **the role of neural therapy in treating a case of atrophic vaginitis**. Atrophic vaginitis is common in post-menopausal women and usually easily treated with topical hormones, but this case was different.

Atrophic vaginitis is usually caused by estrogen deficiency. [Up to 40% of postmenopausal woman may have symptoms](#), but it may also occur during breastfeeding, after ovariectomy or after radiation treatment. Treatment is usually estrogen supplementation either topically or systemically.

My own approach depends on the patient's general health and whether other symptoms of estrogen deficiency are present or not. **I prefer to optimise nutritional status and lifestyle before treating with hormones.** The adrenal glands preferentially produce "stress" hormones over "sex" hormones, so reducing stress in the patient's life is a first step, if possible. Decreasing dietary sugars and other refined foods and supplementing vitamins and minerals, (especially zinc) will sometimes improve estrogen production. A variety of herbals may also be helpful.

If these conservative measures fail, estrogen supplementation is in order. **In women whose only symptom of estrogen deficiency is vaginal dryness, topical estriol applied to the inside of the vaginal labia will usually solve the problem.** If other symptoms are present such as hot flashes, insomnia, etc. additional estrogen in the form of estradiol may be added.

Supplementary estrogen has a bad reputation in some circles because of the association with heart disease and cancer. However this association is entirely with synthetic estrogens and has not been tied to bio-identical hormones. In fact estriol is cancer protective, at least for estrogen sensitive breast cancers and [is used in Europe](#) post-breast cancer treatment in place of estrogen-suppressing drugs such as Tamoxifen.

So how can neural therapy play a role in treatment of atrophic vaginitis?

*This 66-year old otherwise healthy married woman actually presented with chronic digestive problems. It was during the course of investigation and management of these problems that she mentioned the vaginal symptoms. She had had a hysterectomy at age 42, but **the vaginal dryness had begun after a breast lumpectomy, chemotherapy and radiation for breast cancer at age 61.***

A 24 hour urine collection to assess estrogen levels showed low estrogens overall (8.5: range 0-41), but especially of estriol (2.7: range 0-30). The "estrogen quotient" or ratio of estriol to estradiol and estrone was 0.5, far below the recommended minimum (for cancer



prevention) of 1.0.

*In addition to treating her gastrointestinal problems and optimizing her nutrition, **estriol cream 1.25 mgm daily was prescribed for days 1 to 25 of the month.** After two months no change in symptoms was reported so the dosage was doubled to 2.5 mgm/day. This also resulted in no change so a careful search for interference fields was undertaken.*

***Autonomic response testing** produced no suspect interference fields in the pelvis or in the surgical scars. **A weakening was found on touching tooth space 2.1** (left middle upper incisor). Because this lies on an acupuncture meridian corresponding to the genitals, it was considered suspect.*

Neural therapy of the tooth space** (using an "energetic" Tenscam device) resulted in an immediate response in the tooth space as judged by autonomic response testing. The patient "felt better" overall for 24 hours and the vaginal dryness improved slightly. One month later the vaginal dryness had improved some more and again an interference field was found at tooth space 1.1. A repeat treatment resulted in further improvement. **Repeat examinations over the ensuing two months showed no return of the interference field and continued gradual improvement in vaginal health.

The patient has now gone to a warm southern place for the rest of the winter, so I will not see her again until next spring. Nevertheless, **her response to neural therapy was a reminder of how interference fields can lurk behind all sorts of chronic conditions.** Certainly radiation and chemotherapy are well known to cause diffuse collateral damage, but the body's capacity to recover is also dependent on healthy autonomic nervous system function and unobstructed flow of energy through the acupuncture meridea.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

I think most neural therapists would agree that **finding interference fields is one of the most intellectually satisfying things we do**. This is especially true if the patient responds well and lastingly to treatment. However good and lasting responses do not always occur. The reason in these cases is that something is continuing to irritate the interference field. In other words (as Janet Travel would say about muscle trigger points), there is a "**perpetuating factor**".

An example might be an **interference field at the gastro-esophageal junction** causing reflux. These are common and often respond nicely to injecting a few quaddles of dilute procaine into the skin over the interference field, or treatment with a Tenscam or some other energetic device. However if the reflux does not respond well, or returns after a short period of time, the perpetuating factor(s) must be found and dealt with. In the case of reflux, a common cause of continuing irritation is a food sensitivity.

Another example might be an **interference field in the liver**, often associated with fatigue, depression, nausea or malaise etc. Neural therapy is a useful tool in treatment but will not achieve lasting success if the patient has had or continues to have a toxic exposure to (for example) organic solvents. Usually the patient will need to undergo some sort of detoxification as well as discontinuing contact with the offending toxin.

When I was first learning neural therapy, the interference fields that responded poorly or recurred after treatment were a source of frustration to me. I wondered if I were doing something wrong or missing more important interference fields. However as the years have gone by, **I am more and more finding these difficult interference fields to be intellectual challenges in their own right** that provide their own satisfactions when solved.

Before presenting a couple of cases illustrating this, I want to first mention that I have recently read a book that I can recommend and which pertains to this subject. It is called "**Vitamin K2 and the Calcium Paradox**" by Kate Rheaume-Bleue. The theme of the book is that **Vitamin K2 plays a critical role in the distribution of calcium** in the body - directing it to bones and teeth and preventing it from accumulating in soft tissues such as coronary arteries, tendons and kidneys. And **vitamin K2 deficiency is common in western society**.

This knowledge came to mind while treating an otherwise healthy 66-year old woman with **delayed union of 4th and 5th metatarsal fractures** of her left foot. In my experience, **delayed union of fractures respond quickly and well to neural therapy** - relief from pain and signs of new healing appearing on X-ray within a week or two. However in this case, my patient's response was inexplicably slow. Her foot pain was complicated by referred pain from trigger points in the extensor digitorum longus muscle,



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but even with treatment of these, months were passing by with only very slow progress. It was then I decided to check (through autonomic response testing) if she might be **vitamin K2 deficient** and indeed she was. **Supplementing 240 mcg per day (in addition to the vitamin D and A she was already taking) resulted in marked improvement in pain and swelling within a week or two.**

A second case was even more unusual - also in a healthy woman in her sixties. She had a chronic (thankfully mild) nagging **pain in her right flank** that she attributed to a (documented) kidney stone. She was refusing surgical treatment because the pain was not bad enough to warrant the risks of surgery. What caught my attention was that **she could not take vitamin D, even though her serum level was very low**(42 nml.L or 16.8 ng/ml), **because oral supplementation made her "kidney ache"**. (She did not have sarcoidosis!) Autonomic response testing indicated an interference field in her right kidney, which responded to the presence of vitamin K2.

I recommended that she take oral vitamin A and K for a week before challenging her kidney with vitamin D. This she did and **experienced no kidney pain even after a full week of vitamin D supplementation.**

We know from Pischinger's research that interference fields can profoundly affect the body's biochemistry. It should come as no surprise that chemistry and other systemic factors can affect interference fields. **So when interference fields keep coming back after good neural therapy treatment, it is time to look for "perpetuating factors"**. This is when we must draw upon all our medical knowledge, go beyond the simple nervous system paradigm and consider what might be irritating the interference field and causing it to recur.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

I recently attended an osteopathic manipulative workshop - a brain-stretcher in more ways than one. It was a three-day course sponsored by the American Academy of Osteopathy, taught by [Bruno Chikly, MD, DO](#) and entitled "**Palpating and treating the brain, brain nuclei, white matter and spinal cord**". This might sound far removed from anything to do with neural therapy, but I picked up some ideas that I believe are worth sharing.

I have often written about **the similarity between interference fields and what osteopaths call "somatic dysfunction"**. Both are focal areas of dysfunction; both can create disturbance locally or remotely; and in both the autonomic nervous system plays a prominent role. A knee scar might cause pain in the knee or in a shoulder. A somatic dysfunction of a sacroiliac joint might cause pain in the low back or a headache.

Cranial osteopathy is a unique discipline in that it includes the mechanics of the cranial bones and the attached soft tissues as well as the rest of the musculoskeletal system. **Dr. Chikly carries cranial osteopathy a step further by incorporating the contents of the cranium and spinal cord**, even those structures with no mechanical attachment to the cranial bowl. For example he will speak of somatic dysfunction of a lobe of the cerebellum, of a nucleus of the thalamus or even of a basal nucleus.

How can this be? Even if these things exist, how can they be diagnosed, let alone treated? The answer seems to lie in "**tuning in**" to **intrinsic rhythms of the brain**. Cranial osteopaths use this technique by "tuning in" to the primary respiratory rhythm, a slow, wave-like "opening and closing" of the whole body at about [10 to 14 cycles/minute](#). Other fluctuations exist, such as the Traube-Herring oscillation, supposedly mediated by the sympathetic nervous system. Chikly tunes into one of these in the brain (the "**universal rhythm**") at about 2 or 3 cycles per minute. In one phase one hemicranium rotates anteriorly on a horizontal axis while the opposite side rotates posteriorly. At the end of each phase there is a pause of a few seconds before each hemicranium rotates in the opposite direction. "Tuning in" and "balancing" this movement down-regulates the autonomic nervous system and prepares it for the next step.

The next step is to identify somatic dysfunction of specific structures within the brain. ("Somatic dysfunction" here could just as well be termed "interference field".) In one basic technique, the operator places his or her thumbs about one inch apart on each side of the sagittal suture of the supine patient just anterior to the coronal suture. The touch should be very light, while the operator concentrates his or her "**mind's eye**" **on the different layers of the brain from superficial to deep**, feeling for the presence of a disturbance at each level.

With the thumbs positioned as described above, one passes through the cerebral longitudinal



fissure to the **Indusium Griseum**, a thin layer of grey matter covering the superior surface of the **Corpus Callosum**. The Corpus Callosum has both medial/lateral and longitudinal striae and both directions should be tested for tension in the tissues. (Repositioning of the fingers is required for testing the longitudinal striae.)

Going deeper still, below the Corpus Callosum are **the two lateral ventricles separated by the Septum Pellucidum**. The Septum Pellucidum attaches inferiorly to the **Fornix**. (Again some change in position of the fingers is necessary to evaluate these structures.) Similar techniques are used to assess **the thalamic nuclei, the hypothalamic nuclei, the basal ganglia, the brain stem nuclei, cerebellum, etc.**

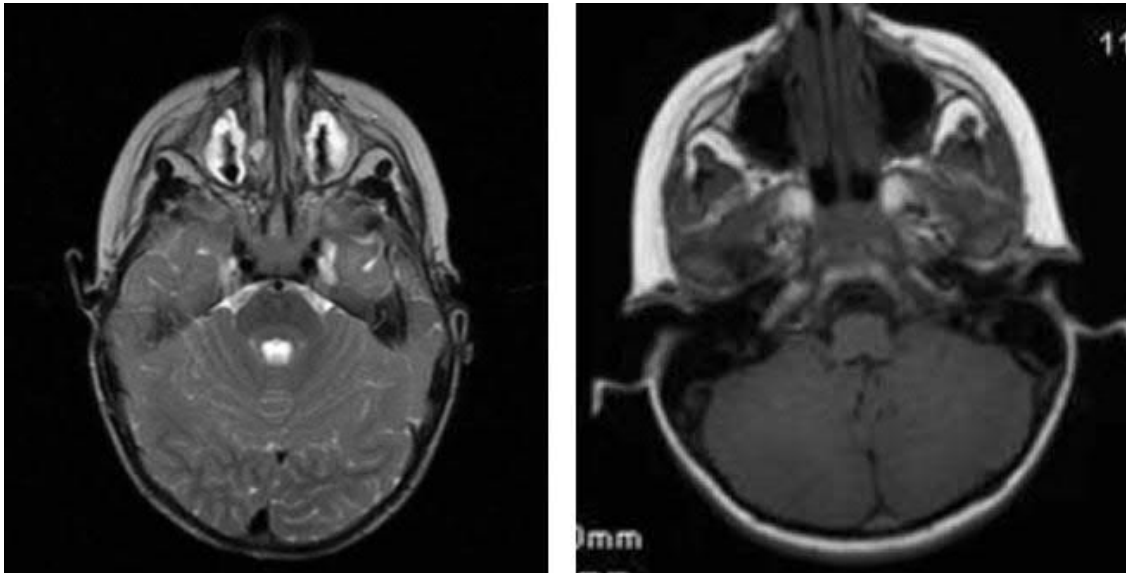
I came home from this course somewhat overwhelmed by the anatomy that I needed to (re)learn. However even a little knowledge raises possibilities and soon after returning to my office I saw a 56-year old woman with right sided Parkinson's tremor and muscular rigidity. She had been diagnosed with **Lyme disease** a few months before and was responding nicely to treatment. However she had a most distressing **right buttock and posterior leg pain** that had not responded to any treatment, including osteopathic manipulation.

Because she also had **panhypopituitarism**, (common in Lyme disease) I decided to assess her pituitary gland. In fact a somatic dysfunction was found and I treated it. Within minutes her leg pain disappeared and it has returned only partially in the last two months.

So what does this have to do with neural therapy? **Interference fields within the brain no doubt exist**, but classical neural therapy does not have the tools to diagnose or treat them (other than the "crown of thorns" and perhaps injection of cranial and/or cervical autonomic ganglia). This is where an energetic model of neural therapy may come into its own. If an interference field is looked upon as a disturbance of the body's energetic field, energetic methods of diagnosis and treatment may provide answers that procaine injections cannot.

The manual skills needed to practice Dr. Chikly's method are demanding and likely possible only for high-level osteopaths. However **other tools exist for assessing intracranial structures**, including [homeopathic testing vials with "signatures" for each cranial structure](#). Scalp and ear acupuncture may also provide avenues for treating specific intracranial interference fields.

Below are two pictures (kindly shared by Dr. Chikly) showing how intracranial structures can be moved using osteopathic "energetic" techniques. This 2-year old child with nystagmus, headaches and insomnia, (requiring codeine to sleep each night) was cured of headache and slept normally after one treatment. Although not equal cuts, **the shift in the sagittal sulcus is obvious**.



I have always considered neurology to be an intellectually stimulating but therapeutically depressing medical specialty. This is especially true when the only treatment options are drugs or surgery, but it seems that times are changing. **Neural therapy (in its broadest sense) may have diagnostic and treatment possibilities in the central nervous system that we could not have imagined only a short time ago.**



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

This month I would like to present **an unusual case of post-concussional syndrome**. Last month I wrote about intracranial interference fields; this month I want to demonstrate that **extra-cranial structures can contribute to post-concussional symptoms too**.

A 48-year old carpenter presented with headaches, memory loss, neck pain, insomnia, impulsivity, photophobia, tinnitus and fatigue since a motor vehicle accident 1 ½ years before. In the accident he had sustained a blow to his right cheek, causing loss of memory for a few minutes. The next day he experienced dizziness, fatigue, confusion and an upset stomach.

*His **past history** included a cerebral concussion in his teens with ten minutes loss of memory. A head-on motor vehicle collision in his twenties resulted in a fractured arm, a "whip-lash" syndrome and resultant chronic low-grade neck pain.*

***Numerous investigations** followed with little in the way of abnormal findings except for a "low DHEA". He rated his energy level at 5 on a scale of 10. His symptoms persisted and the diagnosis of "post-concussional syndrome" was made. He had attempted to return to work (unsuccessfully) as both he and his co-workers noticed that he was making mistakes.*

***On examination**, neck rotation was restricted toward the right; atlanto-axial rotation was restricted toward the left and cranio-sacral motion was restricted throughout the cranium and in the sacrum. "Arcing" (a 60 cycle/minute pulsation emanating from a specific locus, usually indicating trauma) could be felt from the maxilla and extending into the cranial base. This was treated using an osteopathic unwinding technique; cranio-sacral motion was greatly improved and atlanto-axial motion was restored to normal.*

Autonomic response testing** produced a "**therapy localization sign**" ([page 51 of my neural therapy book](#)) corresponding to **an interference field in tooth 1.6** (#2 in the American system) that had undergone a root canal procedure 5 years before. The tooth was asymptomatic but tested as if a chronic infection were present. **Neural therapy using a dental homeopathic was instituted and open regulation resulted.

Six weeks later the patient reported that he "felt better than (he) had in years". And his serum DHEA increased to normal range.

Post-concussional syndrome has attracted considerable attention among researchers in recent years. This is being driven partly by the need for information for advising athletes about when (or whether) they can return to play. The other patient group being studied are soldiers who have sustained concussions from direct head trauma or "blast injuries" (from explosives). Because many of these injuries have occurred in combat, the clinical picture is



complicated by the prevalence of concurrent **PTSD (post-traumatic stress disorder)**.

Most of the research has concentrated on measuring psychological and neurological deficits, but **blood tests have been discovered** that are bearing fruit in research and may soon have application clinically. [Plasma biomarkers including S-110B and SDE](#) have been shown to correlate with brain and spinal cord pathologies including strokes, brain injury during cardiac arrest, vertebral fracture, brain inflammation, etc. They appear to be sensitive enough to be useful in studying and prognosticating relatively minor cerebral concussions as well. This tool has also helped uncover a genetic factor in how the brain copes with trauma. **One intriguing paper has shown that the brain does not do well when the APOE4 gene is present.** This is the gene that is a major risk factor for Alzheimer's Disease.

As exciting as this research is, **I get the feeling that clinicians are well ahead of the scientists in understanding (and treating) post-concussional syndrome.** Cranial osteopathy has been a safe and effective treatment for many years. Neural therapy can also be helpful, through the "crown of thorns" or by treating cranial and/or cervical autonomic ganglion. In short, we know that the autonomic nervous system has a lot to do with post-concussional syndrome.

In the case presented above, part of the irritation of the nervous system was an infected root canal, possibly activated by direct trauma to the jaw. It is difficult to say how much of his symptoms could be attributed to the cranial somatic dysfunction, and how much to the tooth. (I often find that classical interference fields and somatic dysfunction are intertwined - treatment of one correcting the other.)

The "take-home" is **how the brain reacts to trauma is not entirely determined by intra-cranial pathology.** Much of the response is decided by the autonomic nervous system and extra-cranial factors are important in that process.

Comprehensive Neural Therapy Training:
Six three-day segments over two years, followed by examination and certification. Taught by: **Dr. Uli Aldag MD** of Berlin, Germany.
Hosted by: **Dr. Michael Gurevich MD** of Long Island NY.
First session: June 19-21, 2015 in Long Island, NY.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

Have you ever considered that **dental cleaning might be a health hazard?** (I don't mean brushing one's teeth, but rather the professional dental cleaning by hygienists.) Most experienced neural therapists probably are aware of this, but for the sake of those who are not, I want to present a case where dental cleaning made a patient quite sick, albeit for only a few weeks.

I am not referring here to the transient septicaemia that puts patients with damaged or artificial heart valves at risk. These patients are aware of this danger and take prophylactic antibiotics as protection. **A subtler effect of dental cleaning is the release of mercury from the periodontal soft tissues.** This applies not only to those with amalgam in their teeth, but to anyone who has had dental amalgam, even if removed many years before.

About six years ago I reported [a case of mercury toxicity resulting from oral surgery](#) (June 2009). This case is similar but caused by simple dental cleaning.

A 65-year old woman presented with left-sided headaches, sensitive teeth on the left side, fatigue and elevated blood pressure (averaging 185/87) for about a month. Left sided headache and fatigue were not new symptoms for her, but she had been gradually improving since removal of her dental amalgam eight months before and undergoing a mercury detoxification program. In other words, she was undergoing a relapse and the reason for this was not clear.

I had begun seeing her 1½ years before. She had had fatigue from early in life and this had worsened in recent years. She was becoming increasingly depressed and was taking bupronion (Welbutrin). From her initial presentation, it was clear that she was suffering from mercury toxicity. Autonomic response testing supported this impression, as did laboratory investigation. However the lab also raised some red flags:

Serum creatinine hovered around 107; the Quicksilver Tritest showed elevated serum inorganic mercury and depressed excretion through the kidneys; salivary cortisol levels were depressed; serum homocysteine was elevated at 12; and serum vitamin D was 53 nmol/l (23ng/ml). The patient was also gluten sensitive and hypothyroid.

Before amalgam removal her nutritional status and detoxification capacity were optimized over a period of eight months. Autonomic response testing indicated a liver interference field from time to time that was treated by neural therapy, liposomal glutathione and IMD (Quicksilver Scientific). Her thyroid and adrenal glands were supported; her creatinine level dropped to 93 and she was feeling better.

All five amalgam fillings were removed in one sitting, followed within a few hours by an



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intravenous infusion of 25 gm. vitamin C and 250 mg DMPS in Ringer's lactate. The liver and kidneys were checked for interference fields before discharge by autonomic response testing.

For the first two months the patient did well with increased energy, mood and sense of well-being. Intravenous DMPS was administered every month, but surprisingly little mercury was excreted in the urine. At three months, the patient's fatigue and depression began to return. Serum creatinine increased to 111. Interference fields were found on different occasions in both kidneys, liver, thyroid and adrenals and were treated with neural therapy. Over the following months there was a gradual overall improvement.

At eight months the patient again took a significant turn for the worse. Her left sided headaches and sensitive teeth returned as well as fatigue and elevated blood pressure (up to 199/99). The cause of this relapse was a puzzle until the patient volunteered that she had her teeth and gums cleaned about three weeks before.

Autonomic response testing showed interference fields in both adrenal glands with an autonomic reaction to mercury. Neural therapy was administered and Liposomal Glutathione and IMD were resumed. Two weeks later the patient's headache and teeth pain were much better; the blood pressure had normalized and her energy was improved.

This patient's problems were complex. She had fatigue and depression of many years standing as a result of chronic mercury poisoning from her amalgam fillings. **Detoxification was slow and difficult because of poor excretory ability of her kidneys and liver.** Neural therapy played an important part in her treatment, but **her progress was interrupted when she had her teeth professionally cleaned.**

I have seen symptoms of mercury poisoning appear a number of times after dental cleaning over the years. Typical is unexplained fatigue, sore throat or generalized aching of several months' duration. Most of the time the patient does not make the connection with the dental cleaning. Whenever a patient presents with a new symptom, among the possible triggers that I inquire about is dental cleaning.

Hopefully these reactions will occur less frequently in the future as mercury amalgam is phased out of dentistry. However in the meantime **it can be profitable to ask patients about dental cleaning when new symptoms begin with no obvious cause.**

Letters ([about May's newsletter](#)) :

This is correct Robert, Trauma awakens interference fields anywhere in the body. Memory cell information reacts and blocks regulation with many kinds of trauma. Scalar Energy works very well to treat IF inside and outside of the body (biocampo). But it is important for the doctor to know, where you are sending your scalar energy and your intention.

Carlos Chiriboga MD



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Ecuador

I agree that in treating post concussion syndrome / PTSD one must pay attention to the whole person. From my studies in clinical homeopathy this past year I have found Natrum sulphuricum 30C to work well as an adjunct to the other therapies I am using.

It is exceedingly interesting to me that some of the recent research into the action of homeopathy has shown it to [alter gene expression](#) and hormone levels both in animal and human studies.

Rob Banner MD

London, ON,

Canada

Isn't APOE4 the gene that prevents the excretion of heavy metals?

Pierre Larose,

Montreal,

Canada

My reply:

Yes indeed. You are probably thinking of that [excellent paper by the New Zealand dentists](#). I suspect that this property of the APOE4 gene supports our suspicion that mercury is a potential contributing factor to Alzheimer's.

For this reason, I encourage anyone with early Alzheimer's in their family to be tested. If they carry even one copy of the APOE4 gene, I recommend that their amalgam fillings be removed and that they undergo a thorough detoxification program



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

This month I would like to present **an intriguing case of dementia**. Neural therapy was not used in treatment, but an interference field was detected in the small intestine by autonomic response testing. And this proved to be the key to both diagnosis and successful treatment.

There was more to this case than simply dementia. The patient actually presented with **night time seizures**, but it was the decline in memory that was the most worrying, because the patient's father had suffered from early-onset Alzheimer's disease. Here is the story:

An otherwise healthy 64-year old man presented with grand mal seizures, always at 4 am and beginning two years previously. At first they occurred every three months, but then became more frequent and severe. During this period both the patient and his wife noticed a gradual decline in memory.

Many investigations resulted in no diagnosis and the patient was prescribed Levetiracetam shortly before I first saw him. Because of the lack of diagnosis, the patient and his wife sought out alternative therapies in another country and the patient underwent four sessions of intravenous EDTA chelation - which seemed to help his memory.

On his first visit, a medical and structural examination was unremarkable. A search for interference fields using autonomic response testing (or ART) in the cranial vault, brainstem, teeth, and viscera detected nothing. Because of his positive clinical response to EDTA chelation, an intravenous DMPS provocation test was performed with only minimal amounts of mercury and lead appearing on urinalysis. .

*However, routine blood testing showed one unexpected finding: a mild **eosinophilia** of .700 cells/ μ L. Eosinophilia is in my practice a "red flag" for intestinal parasites and/or Lyme disease. On the next visit, a more careful check for interference fields was undertaken and one was found in the small intestine. Homeopathics for various infectious organisms were tested by ART and a response was obtained to **Herpes Type 1 virus**, with **reversal of the response in the presence of colloidal silver** (Mesosilver) and EPA (Eicosapentanoic acid). The patient was prescribed both Mesosilver and EPA.*

*Three months later, his memory was improving and **at 10 months his memory and cognition was "back to normal"**. However 1 1/2 years later he returned with his memory again deteriorating. **The interference field in the small intestine had also returned with herpes virus the causative agent**. This time there was no autonomic response to colloidal silver, but fortunately there was one to the herb Samento (cat's claw). Two months of Samento and **his brain function was again restored to normal**.*



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Although this patient had a dramatic improvement in his dementia with treatment by colloidal silver (and later Samento), a number of questions arise: Why the small intestine with neurological symptoms? Was the herpes doing its damage in the gut or in the brain? How does colloidal silver work anyway?

While researching these questions I stumbled across some ideas that might explain not only how this patient got better, but also provide fresh insight into our understanding of how neural therapy actually works.

The work I am referring to is that of **W John Martin**, a controversial pathologist and immunologist who has developed a theory of [stealth viruses](#) ("stealth" because they do not trigger an immune response). In addition, he postulates that there exists an "**alternative cellular energy**" pathway that is damaged by stealth viruses, but can be repaired by various "activating" substances including colloidal silver and procaine! Classical neural therapy theory recognizes that procaine is a sodium channel blocker and that it treats interference fields by repolarizing partly de-polarized cell membranes. But **perhaps there is more to procaine than that.**

If in fact procaine repairs damaged "alternative cellular energy" pathways, we may have to rethink the nature of interference fields. They may be far more complex than we have thought for these many years. [Dr Papathanasiou \(newsletter Vol.8, no.10\)](#) has already proposed that **interference fields are capable of signalling the immune and endocrine systems.** And **autonomic response testing allows "questioning" of the interference field** for information about what is causing it, why it is persisting and even remedies for correcting it.

The case presented above leaves **many unanswered questions.** Can a "stealth" virus explain the patient's symptoms? If so, why did the interference field present in the gut? We know there is a strong brain-gut connection, but this patient had no gastrointestinal complaints. What was the cause of the eosinophilia? Could there have been a parasite co-infection? Does this patient have tick-borne illness (Lyme disease)?

I apologise to readers for posing more questions than providing answers, but **I would be interested to hear if anyone knows about stealth viruses and especially if they have found an interface with neural therapy.**



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

I am often asked (by patients) my opinion as to the pros and cons of **dental implants**. Usually this is occasioned by the dentist recommending an implant either as an alternative to endodontic treatment, or to replace an extracted tooth, or to anchor an unstable denture. I cannot say that I have any easy answers.

Most (but not all) of my dental colleagues like dental implants. Implants seem to be safer and more predictable than endodontic (root canal) therapy. Also they can be placed in locations where bridges are not an option. Unlike bridges, no collateral damage occurs to the enamel of adjacent teeth. And they provide stability to dentures for those patients with significant bone loss. Lastly, patients like them and their track record over the last two decades is good - from a dental perspective.

However the neural therapist (and some biological dentists) might look at the situation from another angle. Implants, whether of stainless steel, titanium or zirconium (ceramic) are foreign bodies and **challenge the immune system** in a number of ways. [Nickel](#) in stainless steel is well-known to be allergenic. [Titanium](#) is less so, but still provokes a lymphocytic immune response. Zirconium seems to be of low allergenicity, but [doubts have been expressed as to its durability](#).

A second cause for concern is the implant's location. **Every tooth sits on an acupuncture meridian** and we know that the implant (like a root canal) will put stress on the organs and structures that share that meridian. And thirdly implants are [subject to infection](#), as one might expect when so close to the "dirtiest cavity in the body".

These risks are obvious, but are there others? **A Pubmed literature search** shows almost nothing. Many papers study pre-existing medical conditions' effect on implants, but **nothing about implants' effect on systemic health**. This should not be a surprise as almost all the literature on implants is found in dental journals.

For the most part implants seem to be safe, but I have seen a few cases that make me cautious. One was a woman in her late thirties whose implant was infected soon after placement. Within a month she had full-blown generalized **rheumatoid arthritis**. Removal of the implant sadly had no effect and she was left with the disease.

Another case was a 70-year old woman with **chronic neck pain**. The pain so limited her neck movement that she had given up driving her car, as turning her head to look at the side mirrors was impossible for her. I did my best treating her in conventional ways to no avail and finally suggested that perhaps the implants were the cause. She was reluctant to give them up because they had help secure her wobbly lower denture, but finally asked the dentist to remove them. **While in the dentist's chair**, after the second implant (of two) was



removed, **she suddenly felt her neck free up and her neck pain disappear.**

Another case of implant trouble appeared in my office recently. A vigorous, athletic 67-year old man presented with **oro-mandibular dystonia** that had begun 2 ½ years before. The onset was sudden. He was giving a presentation to a group of athletes when he felt difficulty moving his lower jaw. This progressed to the point that his jaw frequently protruded forward especially when trying to speak. Characteristically distraction, (as while picking a tooth) controlled the movement, as did lying on either side.

He had **two adjacent dental implants** placed in his left lower jaw two years before the onset and veneers bonded to his upper incisors in the preceding year. On examination using autonomic response testing he had a **therapy localization sign on the left** side (see chapter 5 of <http://www.neuraltherapybook.com>) and **interference fields in his first two left lower molars** (3.6 and 3.7) (18 and 19 in the American system) **that matched the therapy localization sign.**

At this point it is premature to say that his dystonia was caused by the dental implants. However the literature reports [oromandibular dystonia being triggered by dental procedures](#). Other causes include [medication, trauma, genetic factors, neurodegenerative disease, cerebellar and tardive disease](#). According to [Neychev et al](#), dystonias "can arise from a vast array of acquired insults to the nervous system".

This last statement is consistent with [Speransky's theory](#) that pathological processes arise from an "irritation" of the nervous system. It also fits with the experience of neural therapists who have seen a wide variety of syndromes develop from seemingly innocuous interference fields.

I am in the process of investigating this patient further before confronting the issue of **whether the implants should be removed. This is a difficult call** because there is no guarantee that his syndrome will improve. Also the two-year interval between placement of the implants and the onset of symptoms gives pause. Has some other factor entered the picture to tip the balance?

The pioneers of neural therapy taught that any syndrome, no matter how complex, could be caused by interference fields and that neural therapy should always be tried - knowing full well that some efforts would fail. But surgical removal of implants is a bigger step than simply injecting procaine into an interference field.

Prevention is always better than treatment. Until some good medical follow-up studies appear, **I will continue to caution my patients about dental implants.**



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

I have just returned from the **Austrian Neural Therapy Society's conference in Vienna**, and would like to share something of what I learned. The program had a good variety of subjects and speakers from German-speaking Europe and the Spanish-speaking world of Spain and Latin America. In fact close to 60 of the attendees were Spanish-speaking and the lectures were in German and Spanish, with simultaneous translation.

There is much to report, but **I intend to concentrate in this letter on the subject of neural therapy education and the organizations that provide it**. Much of this was new to me, and I hope it will be of interest to you.

As so often happens, some of the most interesting things happen outside of the lecture halls. One evening I had the privilege of dining with **Lorenz Fischer, Hans Barop and Stefan Weinschenk**, all three authors of recent textbooks (in German) on neural therapy. The good news for readers of this newsletter is that **all three books are being translated into English and should be available within a year**. Spanish translations are planned for later.

All three authors are obviously good friends and co-operate in teaching and other matters, so I felt free to ask "**Why three books?**" The answer is that each is written for a different purpose. Dr. Fischer, who teaches neural therapy to medical students has written a 150 page book of introduction to neural therapy; Dr Barop's book is 350 pages long and concentrates more on science; Dr Weinschenk's multi-author book is close to 1000 pages long and serves as a textbook and reference book.

Both Dr Fischer and Dr. Weinschenk are academics and have succeeded in **including neural therapy in their medical school curricula** in Basle, Switzerland and Heidelberg, Germany respectively. Despite this, I understand there is still, after these many years, resistance by the regulatory authorities to accepting neural therapy into mainstream medicine in Germany, Switzerland and Austria.

In contrast, **the acceptance of neural therapy and other "alternative" medical systems into some of the Spanish speaking countries is nothing short of spectacular**. I have already written about South American neural therapy in [other newsletters](#) (Vol.6, No.4), (Vol.7, No.4). Many thousands of South American physicians are practicing neural therapy and other non-mainstream disciplines, such as acupuncture and homeopathy.

Dr. David Vinjes, of Barcelona, (who spoke at the Austrian conference and is editor of the [Spanish language neural therapy newsletter](#)) has created a 1500-hour **Master's program in neural therapy at the University of Barcelona**. This is having an impact on medical students and the medical community at large. Neural therapy is being accepted (and paid for) by some government-run medical services. Interestingly neural therapy has been



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particularly well received by gynecologists and courses are being offered especially for them.

It is in Columbia where some of the most impressive advances have been made. **A two-year post-graduate Master's program is offered in three streams: oriental medicine, homeopathy and neural therapy.** Apparently already 40 specialists in neural therapy have already graduated.

Dr. Eduardo Beltran, director of the Alternative Medicine program and Dr. Laura Pinilla, director of the neural therapy stream were present at the Austrian conference. Both gave lectures that reflected the **serious thinking about neural therapy** that is taking place at their school. Drawing upon similar sources as Pablo Koval in his book [Neural therapy and self-organization](#), Dr Pinilla explored ideas of non-linear physiology as presented by [Ary Goldberger](#) and [Walter J Freeman](#).

The connection between interference fields and symptoms, so often in remote locations of the body, **has been a mystery from the beginning of neural therapy.** Understanding that the pathophysiology of chronic pain and disease follows the rules that govern dynamical systems is a start to making sense of these relationships. Finally, answers from chaos theory as applied to neurophysiology are pointing us to solutions in neural therapy.

Some of you may be interested in a [presentation that I recently made to the IAOMT](#) (International Academy of Oral Medicine and Toxicology). The first part is primarily about classic neurophysiological principles; the latter is a brief introduction to neural therapy.

Letters:

Thanks for an excellent summary of bio-energetic testing. Many physicians use manual muscle strength, VAS testing of the peripheral arterial pulse or EAV measurement of galvanic skin conductance as indicators of the brief generalized autonomic stress response to a brief stimulus. While I can appreciate the hesitation to embrace 'energy', it is important to recognize that the best scientific explanation of its mechanism is to be found in the basic anatomy and physiology of the extracellular matrix, which is near and dear to the hearts of neural therapists.

The fundamental transducer of electromagnetism in the body is collagen. This piezoelectric molecule can be thought of as a wire that turns EM frequencies into vibrations - sound waves. Like a tiny violin string or a stereo speaker, collagen fibers have connection to every cell in the body - and every neuron too. This creates an awe-inspiring vision of the human nervous system that includes connective tissue - and that enables instantaneous two-way communication between every single cell.



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I would humbly submit that we must eventually create a neural therapy group that embraces bio-energetic testing, and that it is this group that will create the medicine of the future.

Richard Nahas
Ottawa, ON, Canada

I appreciate your description of resonance in your latest neural therapy newsletter. I have long held the only way to eat a healthy diet is eating according to taste. When challenged with, "What about sugar?" I am quick to say sugar, as in sucrose, is not a food. Food, as all else found in nature, is never a single molecule but rather many complexes comprised of innumerable molecules. The same can be said of commercial salt, just sodium chloride (and traces of chemicals used to strip all the other minerals). Salt as found in nature is approximately 85% sodium chloride, the remainder being minerals. So it is through taste, resonance, that the vitality and energy of food are bestowed.

Lynne August
Oregon, USA

First of all thank you Dr. Kidd for providing a forum for neural therapy practitioners. I am in my forty-first year of practice: my father was a dental physician (French trained). I have used dental implants for over 35 years; we placed literally thousands of implants. Implants provide the best structural component in the posterior dentition and in my practice that is paramount.

Implants must be placed by a well-trained practitioner or else they fail. Implants like other procedures fail but if planned and placed properly the success rate is in the 90% range. In serum and Melisa biocompatibility tests, titanium is slightly superior to zirconia and old zirconia implants due to their designs had a very low success rate. Many so called biological dentists started using zirconia implants for financial reasons.

Most medical and dental practitioners have not studied physical medicine or locomotion. So they take an implant out and the neck improves. I am NOT suggesting that an infected implant or an implant placed in a mixed metal environment does not become an interference field!!!!!!.

I invented intra osseous neural therapy in the early nineties and only a few dentists know how to use it properly. I am eagerly waiting for zirconia implants that are designed properly and approved by Health Canada. We will place them according to the milieu of the oral cavity.

I apologize if I am offending some of your readers but facts are facts. There are literally millions of titanium implants in many skeletal areas that have given millions of patients a better quality of life . And some implants placed in the wrong environment have caused a lot of problems such as a disturbance field.

Ara Elmajian
Vancouver BC
Canada



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

I have had two patients in the last couple of months that brought to mind the **importance of the lower thoracic sympathetic ganglia**. These ganglia are difficult to reach with the neural therapist's needle, but important for a variety of reasons.

Both were men in their late sixties. One presented with **recurring testicular pain** following direct trauma 17 years before, and the other with **chronic pain in the groin** following an inguinal hernia repair two years previously. The common denominator of their conditions was an interference field in a lower thoracic (approximately T10 to L1) sympathetic ganglion.

The man with the testicular pain had a history of recurring attacks. These episodes sometimes coincided with "flares" of inflammation of his haemorrhoids, strains of his back, or (on one occasion) a kidney infection. **Sometimes interference fields were found in the testicle, but on more than one occasion interference fields were found in the ipsilateral T10 sympathetic ganglion.** At times more than one treatment was required but he often would be free of pain for more than a year.

The course of **the patient with post-hernia repair pain was more straightforward.** On his first visit a T10 sympathetic ganglion interference field was found on autonomic response testing (none in the scar). His response to treatment was satisfactory but on recurrences the scar interference fields became apparent and needed to be treated twice before the pain disappeared for good.

Chronic pain in the groin or testicle (sometimes called orchialgia) is usually an enigma to urologists and other physicians with conventional medical training. [Testicular pain](#) has been receiving considerable research attention, but because [50% of cases have been considered to be idiopathic](#) the usual suspicions of secondary gain, psychogenic factors, etc. come to the fore. Only [one report](#) (from 1994) recognized the spinal region to be an important source of testicular pain, although disappointingly "radiculitis" was the only explanation on offer.

With such poor understanding of the nature of the pain, it is not surprising that orchietomy is sometimes offered (with variable results). The latest surgical fashion is now [micro denervation of the spermatic cord](#). How sad to see testicular pain joining that long list of conditions for which surgery has been offered, and all for lack of understanding of how the pain occurs!

Occult testicular or groin pain is definitely the realm of the neural therapist! There should be no "idiopathic" pain when the principles of neural therapy are applied. The keys are, as always, to look for sources of irritation of the nervous system: scars, history of



epididymitis or other scrotal infection, trauma, and musculoskeletal disturbance. If no obvious interference fields can be found by history, **Dosch recommends a series of test injections** of dilute procaine: quaddles into dermatomes T10 to L3 and S2, direct injections into the spermatic cord or testicle, pudendal nerve blocks, and epidural or presacral infiltration (p. 243 of Dosch's *Manual of neural therapy according to Huneke* - 2nd edition).

Personally, I have found that if no interference field is apparent, and even when there is one, but it does not respond well, the key is an interference field in a lower thoracic sympathetic ganglion. **I suspect that these are not often searched for because the injection technique** (page 186 of [my book](#)) **is so intimidating**. Sliding a three-inch (7.5cm) needle under the lung with the patient in expiration is one of the more challenging injections in neural therapy. My guess is that most neural therapists resort to it only when all else fails.

I have done a number of them over the years, but each occasion did not fail to elicit a light sweat and relief (on my part) when it was over. Thankfully, most times it is a therapeutically rewarding procedure.

However, the lower thoracic sympathetic ganglia is an area where an energetic approach truly shines, both in diagnosis and treatment. Autonomic response testing (if positive) gives the assurance that an injection is worthwhile. And **energetic treatment (I use the Tenscam device) is as effective as the injection, much faster, and with none of the risks.** Previously, I would have to schedule a special appointment for the injection procedure. Now, I can include a treatment (which takes about a minute) into the appointment and can treat as soon as the interference field is found.

My experience is that energetic treatment is as effective as procaine injections, but I have to be careful when I say this. I really have not had enough feedback from other practitioners to be sure that this is true. **It would be very helpful if those who do use energetic treatments (especially of autonomic ganglia) would share their experience with readers of this newsletter.**



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

Neural therapists have known for a long time that **the wisdom tooth (or wisdom tooth space) is a common interference field**, and one with potentially major repercussions on the body's health. It is common (approximately **50% of dental interference fields**) and has wide-ranging effects from the anterior pituitary gland to the heart, the small intestine, the sacroiliac joint and the foot. (See the Voll dental acupuncture chart on pages [166 and 167 of my book](#), or page 97 of *Manual of neural therapy according to Huneke* (2nd English edition) 2005.)

One of the more interesting connections of the wisdom tooth is to the inner ear. Unilateral tinnitus can be a very satisfying condition to treat, when a wisdom tooth interference field is found. **A wisdom tooth interference field can also be connected to the balance organs** and should be searched for in all cases of vertigo or Meniere's syndrome. The following case was particularly interesting because of the way it was precipitated.

*A 61 year-old man presented with **intermittent vertigo of about 2 ½ years duration**. He already had chronic tinnitus for many years, (presumably noise-induced) from his occupation as a well-driller. The spells of vertigo occurred roughly five days in seven, were preceded by a few minutes of malaise, and then came on suddenly,. This minutes-long prodrome allowed him to take precautions, such as pulling off the road when driving. On two occasions vomiting occurred. He had been prescribed betahistidine with minimal effect.*

*Apart from mild hypertension, he was relatively healthy, but he noticed that his vertigo had coincided with extraction of multiple upper teeth and **prescription of a new upper denture**. His wisdom teeth had been extracted long before, and the new plate covered the wisdom teeth locations. He found his denture uncomfortable and did not like wearing it.*

*On his first visit, an interference field could be detected at **tooth space 1.8** (No 1 in the American system). The response could be reversed with the presence in the field of a Sanum remedy (Notakehl). This last finding indicated **occult infection contributing to the interference field**. The interference field was treated with the ultraviolet function of the Tenscam for about one minute. (See [newsletter Vol. 4 No. 10.](#))*

*Six days later the patient reported only two attacks of vertigo, less than his previous pattern. The interference field had recurred and was treated again in the same way. Three days later he reported no vertigo and one week after that he reported only one "little" attack. He also declared that it was his "best week in years". Interestingly on this visit, an interference field could be detected in his right tonsil. It was treated and **he has been free of vertigo ever since** (a month later).*

What I found interesting about this case was that the symptoms were precipitated by an



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uncomfortable denture. **Speransky often referred to "irritation" of the nervous system as being the cause of most disease.** He demonstrated that these irritations triggered dynamic processes, unpredictable in their outcome, but nevertheless following certain rules. Fifty years later, chaos theory provided us a better understanding of how these processes work.

In my patient's case the infection in tooth space 1.8 had been lying dormant for many years. It was only **when the irritation of the denture was added to the picture**, that the dynamic process took place, ending in attacks of vertigo.

Thankfully, in this case he was able to continue wearing his denture, as the dental space interference field was abolished by neural therapy. This is not always the case. For example, interference fields at the gastro-oesophageal junction respond to neural therapy but will always recur if the conditions that precipitated it are not dealt with e.g. food sensitivity, hypochlorhydria, anxiety, etc.

For more case histories relating to wisdom teeth interference fields, I recommend Pablo Koval's fine book: [Neural Therapy and Self-Organization](#).

Good news!

One of the privileges of practising medicine is to share the joys and sorrows of our patients. Sharing sorrow is sobering; sharing joys can be profoundly satisfying.

Last month I wrote about chronic testicular pain and its relationship (in some cases) to the lower thoracic autonomic ganglia. Not long before, I had seen a young married man with **recurring testicular pain**, that responded nicely to a couple of Tenscam treatments directly to the testicle. **He was profoundly grateful for the relief that he obtained.** A couple of months after that he thanked me again, with a big smile on his face. **His wife was pregnant!**

They already had two daughters, eight and six years of age, but had been unable to conceive again. He had never mentioned **a fertility problem** to me, but knowing him personally, I had sometimes wondered. He was from a Mennonite farming background and large families were the norm. I have seen pregnancy result in women after neural therapy to the pelvic plexuses, but this was my first experience in treating male infertility (albeit unknowingly).

Letters:

I have been using Scalar Energy Tenscam treatments for 3 or 4 years with very good results. But from my experience Neural Therapy with procaine injections is faster and more effective than energetic treatments. Of course when we have to do a ciliary ganglion with retrobulbar injections or something like your cases with thoracic autonomic ganglia, or brain stem treatments or limbic area treatments, for sure I prefer Tenscam. We don't want very risky procedures.



Dr. Robert F Kidd, MD newsletter archive
For neural therapy and advanced healing



About orchialgia and chronic inguinal or groin pain, I agree we need to keep in mind the spine and autonomic ganglia. Once I treated my brother with testicular pain with procaine injections in the testicular area and L2 spine level.

Thank you so much for sharing your experiences with us.

Carlos Chiriboga
Guayaquil
Ecuador

I always appreciate your newsletter!

In case you are interested in a new perineal injection technique, please find the abstract in <http://www.ncbi.nlm.nih.gov/pubmed/26374644>. This is the method we are teaching in the gyn courses among many others in July, 2016.

For more details, don't hesitate to contact me.

Greetings,

Stefan Weinschenk
Heidelberg
Germany

Editor's note:

Dr Weinschenk is referring to the Introductory Neural Therapy courses (in English) to be offered at Heidelberg University next July. More information will be posted in coming newsletters.

R.K.

Are the leaders in Neural therapy talking about neurogenic inflammation? John Lyftogt MD from NZ has discovered that 5% glucose settles painful inflamed nerves and thinks that it is related to the capsaicin sensitive nervous system. I can't explain it as well as he can - see attached. The relevance to the thoracic sympathetic nerves is that there are dorsal rami of the spinal nerves that we often treat if painful and tender with the 5% glucose - 1cc about 1cm



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deep, with good results within 5 mins. Not as quick as local anaesthetic of course , but very interesting all the same. Apparently the inflammation goes proximally as well as distally and so does the relief with 5% glucose. I know you use the Tenscam but I'm wondering if the injections would work as well if they weren't so deep?

So back to my original question - I haven't kept up with new research from neural therapy except from you. Is there any discussion about all this?

Thanks

Margaret Taylor
Adelaide Australia

Editor's note:

Thanks for your letter and the attachment from John Lyftogt. I haven't heard any interest expressed among neural therapists in North America about John Lyftogt's method, but I know prolotherapists have. In fact he has given workshops on a number of occasions in Canada and the US to prolotherapy groups. And some of them are enthusiastic about what he teaches.

I have not taken his course, but I have been at conferences where his theory and methods have been presented. The big problem in terms of incorporating it into existing practice is that it seems to deal with problems where symptoms present, and not necessarily where the syndrome begins. This is attractive to prolotherapists who generally treat where the symptoms arise, or at least where the pain-generating trigger points can be found. Osteopaths and neural therapists generally look beyond symptoms.

Since this is basically a clinical matter, I think the best way to evaluate this would be for patients who have "inflamed nerves" assessed by a skilled osteopath and/or neural therapist to see if a cause for the "inflamed nerves" can be found and (ideally) treated successfully. If the inflamed nerves do not respond to osteopathy and/or neural therapy, then successful treatment with Lyftogt's method would be impressive indeed.

What do you think?



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

Is it possible that the incidence of herpes zoster ("shingles") [is on the rise](#)? An interesting case of post-herpetic neuralgia in my office has had me pondering this question.

I had heard the suspicion expressed that varicella (chicken pox) vaccination programs of children were having [the unintended consequences of increasing the incidence of herpes zoster in adults](#). The reasoning is this: The wild virus that causes varicella in children, is thought to also boost immunity to the (dormant) varicella virus in adults. **With the institution of widespread varicella immunization in the last 20 years, the incidence of varicella has clearly declined. Has herpes zoster increased in response?**

This is a difficult subject to research. The quality of epidemiological data is spotty, especially that collected retrospectively from before the vaccine era. The incidence of herpes zoster is age-dependent, is affected by climate and seasons, and is much higher in immune-compromised individuals, so comparison of before- and after-vaccine data is hard.

Some of the most interesting data come from comparative studies of HZ incidence in those who have more or less exposure to varicella, e.g. [paediatricians vs dermatologists and psychiatrists](#) or [adults living with young children](#) vs [those who are not](#). **These small studies show a clear protective effect of wild varicella exposure.** Now that widespread vaccination has been instituted (in the US and Canada) more data of its effect on herpes zoster incidence is available. Goldman and King's review is highly critical of the whole varicella vaccination program and its effect on HZ rates. Another review by Leung et al found increasing incidence of herpes zoster but no evidence that varicella vaccination was a contributing factor.

An excellent overview of this whole subject can be found in chapter 40 of: [Human Herpes Viruses: Biology, therapy and immunoprophylaxis](#).

In recent years, the emphasis in research is to demonstrate the efficacy of vaccines in treating both chicken pox and herpes zoster. Unfortunately the vast majority of these "peer-reviewed" studies have been funded by the vaccine manufacturers.

So now about my patient: *This 65 year-old woman did not actually have active herpes zoster when I first saw her, but rather **post-herpetic neuralgia**. The herpes lesions had manifested above her right hip about a year before with the typical burning "shingles" pain, but the pain (not the lesions) continued down her leg over the anterior thigh to the medial side of her knee.*

Post herpetic neuralgia (or herpes zoster) usually responds to quaddles of dilute procaine injected into the area of skin lesions and/or pain. I have found through autonomic response



testing that **there is usually an interference field in the skin not far from the nerve's exit from the spine**. Treatment of this spot is usually effective, rendering unnecessary treating the whole painful area.

*However in this patient, no interference field could be detected near the spine, nor along the course of the pain distribution **until the knee, where an interference field could be detected along the whole joint line**. The joint was treated with the Tenscam device and the patient had after the first day a day of relief, then some return of pain, but less intense. An interference field could again be detected on the joint line, but only medially and extending a few inches proximally.*

*Similar response and findings were obtained on two more occasions and then **the quality of the pain changed to a muscle spasm**, proximally in the mid anterior thigh. Interference fields were found in ensuing appointments in the pelvic diaphragm, the right L3 sympathetic ganglion and the lateral half of a cholecystectomy scar. Overall improvement continued with treatment but some persisting pain and muscle tightness suggested possibly **magnesium deficiency**. This was confirmed with autonomic response testing; the patient was prescribed magnesium glycinate in increasing doses to bowel tolerance. On the subsequent visit the patient was pain-free, autonomic regulation was "open" and no interference field could be found.*

This patient's post-herpetic neuralgia was unusual in a number of respects.

Firstly herpes zoster is uncommon in an extremity; usually it presents in the trunk or the head. **Secondly**, the first detectable interference field was far from a spinal root, where it is usually found. **Thirdly**, other interference fields, distinct from the herpetic process were involved. And **lastly**, the pain was not completely resolved until a nutritional deficiency was corrected.

My patient's course also demonstrated once again **the principle of neurological summation**: the summation of more than one neurological input to the central nervous system resulting in a signal that reaches threshold, - and then the possibility of **affecting the threshold itself** by correcting a nutritional (or toxic) factor that alters the nervous system's excitability.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

Last month, my case report of post-herpetic neuralgia ended by my administering magnesium after several only partly-successful neural therapy treatments. Magnesium was the final touch that permanently corrected my patient's pain.

In my experience, **knowledge of nutrition is essential for successful treatment of some interference fields.** This is why I devoted a whole chapter of my book [Neural therapy: Applied physiology and other topics](#) to nutrition.

However I have purposely avoided discussing nutrition in these newsletters for two reasons. The first is that many others can write about it better than I can. The other is that information on neural therapy is still in short supply in the English-speaking world of medicine. So neural therapy continues to be my priority.

Having said that, the subject of nutrition can be overwhelming for the uninitiated. Sadly it continues to be ignored in medical schools. So this newsletter I am going to break with policy and simply list some **common nutritional deficiencies that can be picked up in a general physical examination.** These signs are by no means comprehensive, but they are the common ones, at least in my practice.

Before even starting I always ask patients to **rate their own energy level on a 1 to 10 scale.** "10" is all the energy ever wanted; "5" is enough energy to get through the day, but feeling tired all the time; "less-than-5" means unable to get through the day without naps or stopping to rest, etc. **I assume anyone who is less than 7 has nutritional deficiency** and that includes those who are hypothyroid.

Beginning at the feet of my supine patient, I examine the toes. **If the second toes are longer than the first,** the patient is at risk of being **zinc deficient.** I don't know where I learned that, but experience tells me it is true so I then watch more carefully for symptoms and signs of zinc deficiency. I have also been told that smelly feet are caused by zinc deficiency, but I am less sure of that one.

Tight hamstrings was the clue that alerted me to the possibility of magnesium deficiency in last month's patient. I test straight-leg raising routinely and although tight hamstrings have other causes, **magnesium deficiency** should be considered especially if other symptoms such as leg muscle spasms or constipation are present.

Depressed deep tendon reflexes at the ankles is a sign of hypothyroidism which in the Western World is usually autoimmune in origin, but can be due at least in part to **iodine and/or selenium deficiency.** Iodine deficiency is becoming more common with the avoidance of iodized salt and possibly also from competition by other environmental halides,



especially bromine and fluorine.

The condition of fingernails can reflect a whole host of diseases, but the common signs of nutritional deficiency include: **brittle or split nails indicating hypochlorhydria, and white flecks on the nails** (leukonychia) due to **zinc deficiency**. These white spots can be useful to watch when treatment is instituted. Observing the white flecks "grow out" with none replacing them indicates zinc stores have been replenished. **Thin or deformed nails** can be due to iron deficiency and "**clubbing**" in the absence of pulmonary or liver disease is a good sign of **gluten sensitivity**, especially when found in younger people.

Dense, lumpy breasts or breast cysts is a sign of **iodine deficiency** and can be corrected within a few months by supplemental iodine. **Cystic acne, frequent carbuncles and pelvic cysts** may also respond.

A little-known sign of gluten sensitivity is **dental enamel hypoplasia** (white spots in the dental enamel). **Gum recession** when focal, is often a sign of an unhealthy tooth, (especially one restored with mercury amalgam), but when the recession is diffuse, **folate deficiency** should be considered.

Depression has multiple nutritional causes but commonly overlooked ones are vitamin B12 deficiency (don't trust serum levels), vitamin D deficiency, food sensitivities (including alcohol), and any medication affecting liver function.

Hypertension, especially when of recent onset, deserves to be investigated for magnesium or vitamin D deficiency, food sensitivities and insulin resistance.

Rosacea, in genetically vulnerable individuals, is often associated with gastric hypochlorhydria. Improved hydration, increased salt consumption and attention to adequate dietary zinc will improve stomach function, if not the rosacea.

Acne is a hallmark of the western diet, always associated with food sensitivities (especially gluten) and excess dietary sugar, but sometimes requiring nutritional supplementation with vitamin A, D, zinc and omega-3 oils. In fact, many skin conditions improve with these supplements alone.

Dark circles around the eyes suggests intestinal dysbiosis, in particular candida overgrowth. "**Puffy**" **eyelids** indicates allergy, sometimes called "allergic shiners" in children.

Hair in humans, as in livestock and pets, is an external expression of health. **Dull, brittle, or thin hair** has multiple possible causes, but should alert the clinician that improvements in diet and/or digestion or hormone status are needed.

Finally, whenever a sign of nutritional deficiency is detected, treatment should never be limited to that one obvious deficiency. Nutritional deficiencies are always multiple and raise the question "Why?" If the diet is not the reason, digestion and absorption must always be investigated. **Neural therapy** is a powerful method of addressing the body's regulatory controls, but it **cannot be expected by itself to overcome poor diet and an unhealthy *milieu intérieur***.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

One morning this month a 70 year-old woman presented in my office with what she feared was "rheumatoid arthritis" in her hands. Rheumatoid arthritis ran in her family and she was experiencing **pain in both hands - in her thumbs and first metacarpals**. After a brief examination, I reassured her that the pattern was not that of rheumatoid arthritis and that there must be some other cause.

She had been packing her mother's household effects in boxes and suspected that the extra work had provoked the pain, but there was no sign of tendonitis, arthritis or synovitis in her hands. She also had been struggling with a "chest cold" and had been coughing a lot. Looking through her chart I noted that a few years before I had seen her for life-long **asthma and had cured her by neural therapy to her right lung**. Could there be a connection?

My readers who practice acupuncture have probably already guessed it. Yes, she had **an interference field in her lung again**, (as proven by autonomic response testing) and **the pain in her hands coincided the lung meridia**. The "chest cold" had settled, so neural therapy of her lung was all that she needed. (See pages 122-123 of my book <http://www.neuraltherapybook.com>.)

On the same day, I had another patient, a woman in her 50's complaining of **pain in her index fingers**. Again there was no history of trauma or strain and the pain was bilateral. Examination of the hands was unremarkable and the woman was healthy, complaining only of chronic constipation. By this time, I was already thinking, "acupuncture meridia" and sure enough, on autonomic response testing **the large bowel indicated an interference field**.

Neural therapy of the large bowel is of course the appropriate treatment, but particularly **with viscera, I always wonder what triggered the interference field in the first place**. In this woman's case she had begun a "Paleo" diet a month before, mostly in an effort to lose weight, but also to help her chronic constipation.

Sudden changes in diet can sometimes be stressful to patients' gastrointestinal tracts and I suspect this is related mostly to changes (or lack of change) in bowel flora. The balance of strains needs to shift and probiotic support is sometimes required. In this patient, autonomic response testing confirmed this suspicion. Neural therapy was directed at the large bowel, but a good quality multi-strain probiotic was prescribed as well.

I think those who practice both **acupuncture and neural therapy** realize there is



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considerable **overlap between the disciplines**. Many of the points used in segmental therapy of the viscera coincide with acupuncture points. In Germany one of the largest neural therapy organizations is called the Deutsche Gesellschaft für Akupunktur und Neuraltherapie (German Society of Acupuncture and Neural Therapy).

Personally I do not use acupuncture in my practice, mostly because many of my patients live too far away for the regular, repeat treatments that acupuncture requires.

I have a great deal of respect for acupuncture, both the art and the science - (that is slowly being revealed to us by modern research). But **neural therapy's concept of the interference field seems to put it into a class of its own for many situations**.

Speaking of acupuncture research, I have recently read **Jim Oschman's** new release of "**Energy Medicine**" (second edition). A particularly rich section is his review of recent research into the nature of acupuncture points, their connection with fascia and the flow of energy through the meridia (and/or the matrix).

It would seem that there is currently **far more research into the science of acupuncture than that of neural therapy**. (Some of the best is coming from Asia, especially Korea.) However careful reading of these reports will no doubt be of benefit to those of us trying to better understand the mechanisms of neural therapy. Classical neural therapy has served us well, but I believe that **an understanding of energetics will be required to make further progress**. Acupuncturists and neural therapists are on the same journey in this way.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

A 65 year old man presented in my office with a leg problem that had begun a month before with a **sprain of his knee** while walking on a beach in Bali. Apparently a wave had thrown him off-balance while his foot was anchored in the wet sand.

At first the pain was localized to his knee. There was some swelling but it was not severe enough for him to seek medical attention or to delay his long flight home to Canada.

After a few days at home the pain was persisting. It was also moving **below his knee and was accompanied by diffuse swelling of the calf extending down to his ankle.** A visit to the Emergency Room ensued and because of his many hours of air travel, the attending physician (understandably) suspected a **deep vein thrombosis.** However x-rays and ultrasound imaging revealed no circulatory problem.

A week later, the patient was no better. He returned to the Emergency Department; a repeat ultrasound was performed and because of swelling behind the knee, a MRI was performed. The MRI revealed a small **Baker's cyst and a "soleus tear"**. Neither explained the swelling and pain below the knee, which was by this time becoming more prominent in the ankle.

By the time I saw him, the swelling in the mid-calf was subsiding. In fact the swelling **seemed to center more on the lower leg and ankle.** (This was despite the fact that he had not strained his ankle with the injury.) A little farther down the extremity, I noticed a **small violaceous cutaneous cyst** over the dorsum of the distal second metatarsus. The patient explained that the cyst was a re-growth of a previously surgically-removed cyst. It was not tender, but autonomic response testing ([See Chapter 4 of my book](#)) indicated that it was an interference field!

The cyst was treated energetically with a Tenscam device. (Neural therapy with procaine would certainly have achieved the same result, which was abolition of the interference field.) However autonomic response testing showed blocked regulation, which meant that the autonomic nervous system was still not responding fully.

There are many possible causes of blocked regulation, but in an otherwise healthy man, high on the list would be another interference field. **My eyes were drawn to the slightly swollen ankle.** My hands could feel "arcing", a 60 cpm pulsation emanating from the ankle and the ankle had a passive range of motion consistent with somatic dysfunction. The patient also revealed that he had a history of recurring ankle sprains on that side.

There were three options for treating the ankle: (1) an energetic **Tenscam treatment**, (2) **quaddles of dilute local anaesthetic** into the skin overlying the swelling, or (3) **osteopathic "unwinding" of the ankle.** I chose the last option, because I like to feel the



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For neural therapy and advanced healing



"release" of the tissues under my hands - a sure sign of successful treatment. Autonomic response testing confirmed this, as "open regulation" was restored. And **by the next day, the patient's pain and swelling was well on their way to recovery.** A few days later all pain and swelling were gone.

This case was interesting because **an acute injury (to the knee) had the effect of bringing two latent interference fields in the lower leg to the surface.** One was a classic (neural therapist's) scar. The other was a latent ankle sprain. In fact as time went by the effects of the initial injury to the knee subsided and "expression" of the interference fields came to the fore.

In other words, the knee injury had acted as a "**Second blow**" (Speransky) in reawakening the dynamic processes initiated by Speransky's "**irritations of the nervous system**". See newsletter [Vol. 7, No.1](#).

Upcoming meetings:

June 2-5, 2016: [International Neural Therapy Congress](#) in Istanbul, Turkey



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

This month I want to describe an interesting case of **hip and leg pain with a surprising component that was treated successfully by neural therapy**. The patient was an otherwise healthy woman of 62 years whose pain had developed while exercising four years previously. The pain came on suddenly without any preceding trauma or strain, and she had never experienced a similar pain before.

The pain centered in the right anterior thigh, was relieved somewhat by movement and flexing her hip. She slept more comfortably on the opposite side. The thigh muscles felt stiff and with time **slight swelling developed in her thigh**.

The pain worsened so the family doctor proceeded with nerve conduction studies and an MRI, which contributed nothing. A neurosurgical consultation also came up empty. Physiotherapy and chiropractic manipulation provided some help in the beginning, but none as time went by.

Her only previous injury was a fall off a ladder onto her right side eight years before with pain in the hip area lasting several weeks. Her surgical history included a remote appendectomy, tonsillectomy and adenoidectomy, cholecystectomy and hysterectomy.

Physical examination showed a symmetric pelvis anteriorly and posteriorly with no sign of sacroiliac instability. **Mild restriction of straight-leg raising was found on the right and considerable spasm of the right psoas, piriformis and hip adductor muscles**.

This **seemed like a straightforward mechanical problem** that should respond to osteopathic manipulation. Her otherwise good health and relative lack of serious trauma were in her favour. However, **the gradual worsening of her symptoms with time and the mild swelling of her thigh was puzzling**. In fact the swelling, (absent trauma or any sign of inflammation) suggested an **autonomic nervous system component**.

Osteopathic manipulation: "muscle-energy technique" of the hamstrings, piriformis and psoas muscles was conducted, and as I feared, the response **was disappointing**. In an uncomplicated situation, muscles should "release" easily. There should be a "sweet" feel as this happens, as if the muscles are relieved at being freed from their constraints.

In my patient's case, the muscles were stingy and only reluctantly and partially gave way. This is a sign of either a more important mechanical problem (somatic dysfunction) elsewhere, or an interference field somewhere in the body.

I had already examined her from head to toe for somatic dysfunction, so this left **an undiscovered interference field as the likely cause**. One clue was a **depressed affect**. The



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patient admitted to feeling depressed but blamed it on pain and loss of her usual excellent health. Using autonomic response testing, I checked her liver, and sure enough, an interference field was found. When challenged with various substances that can "disturb" the liver, there was a response to DMSO, the "universal solvent". This was a sign that **the liver was being stressed by an organic solvent**. (See chapter 10 of my book <http://www.neuraltherapybook.com/>.) The patient admitted to a hobby of stripping paint from furniture - a high-risk activity for the liver. The patient's **liver interference field was treated with a Tenscam device**; (an alternative would have been quaddles of dilute procaine over the liver and right upper shoulder, according to the Head zones. The patient was instructed to avoid all contact with organic solvents and to eat a diet rich in eggs, garlic, brassicas, and other sulphur-rich foods.

Three weeks later the patient returned feeling "much better". The pain had worsened for one day, and then subsided suddenly and dramatically. Her mood was also much improved. A slight relapse had occurred just before her return visit and on examination she again had tight right psoas, piriformis, hamstrings and hip adductor muscles. Swelling of her thigh also persisted.

This indicated that **another interference field was still present**. A repeat examination using autonomic response testing showed the liver to be clear, but the hip joint itself to be an interference field. Perhaps the hip joint interference field had been silent since the patient's fall on her right side eight years before. And perhaps the toxic effect of the organic solvents on the liver had brought the hip interference field to the surface.

The restriction of motion of the hip joint in multiple directions was consistent with the "**capsular pattern**" described by Cyriax. I was surprised to find that the capsular pattern concept [has been challenged](#) by some studies, but [inter-examiner reliability experiments](#) in turn question the validity of all research relying on physical examination for range of motion. In any case **there is almost certainly a sympathetic nervous system effect in these joint capsule disturbances**. (See related comments on the "frozen shoulder" in [Vol. 2 No. 6 of the archives](#).)

The hip joint interference field was treated with a Tenscam device. Alternative treatments would be quaddles of dilute procaine over the hip area, or an intra-articular injection of 5 cc of procaine ½%.

The result of this last treatment remains to be seen, so I cannot yet give you the end of this story. Perhaps the subject of another newsletter!



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Volume 11, No. 6, June, 2016

NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

This month I plan to discuss **international neural therapy conferences**. By the time you read this, the Turkish one (June 2-5) will have been completed - the 6th one to be held in Turkey. These are large meetings with many interesting lectures and simultaneous translation into English. Over 300 participants attended the previous one in 2014.

There are **two more international conferences** scheduled for the coming year - **one in [Colombia in October](#)**, and **another in [Canada in May 2017](#)**. Plans for the Colombian meeting from October 14th to 16th are now in place, with an impressive line-up of speakers.

Colombia has been a world leader in neural therapy for many decades and the program showcases speakers from the host country. As mentioned before in [a previous newsletter](#) (Vol. 10, No.10), **Colombian National University has been taking a fresh new look at the phenomena described by Speransky** in the 1930s and applying modern (mathematical) techniques to explore them. Although Speransky's work preceded neural therapy, it provides to this day the best explanations of how neural therapy works. But as I am sure Speransky would have agreed, his work was just the beginning of a whole new way of looking at disease. [Pablo Koval](#) (Vol. 8, No. 7) from Argentina will also be speaking on this subject.

Other featured speakers will be coming from South America, Mexico, Canada, Europe, and as far away as Turkey! This is a rich and far-reaching program that should attract neural therapists from around the world. Already a small group of us from North America are planning to attend. Bogota is not that far away from North America, so why don't you join us?

Plans for the conference in Ottawa, Canada are also falling into place. In some ways this is an even more ambitious project, because it will be **the first neural therapy conference ever held in North America**. For the organizers, (a small group of physicians from Canada and the US), this is a "shot in the dark". **No neural therapy organization exists in North America**, so we do not even know how many neural therapists there are, let alone their level of interest and expertise. Nor did we know, (when we started), if we could obtain the top-quality speakers needed to attract physicians from other countries.

So we made up a "**wish list**" - well known, experienced speakers from a variety of countries, all with something original to say. Wishing was a big part of this, as we had little to offer speakers except a warm welcome and the opportunity to help start something new in North America. With a little help from international friends, we came up with a list, sent letters of invitation and held our breath. To our amazement, **every single speaker that we**



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invited not only accepted, but also accepted enthusiastically.

This bodes well for our conference. **These speakers are giving of their time and resources to help neural therapy succeed in North America.** They are committed!

We believe that they also are attracted by **the quality of the [other speakers](#)**. This will be a meeting at which they can learn as well as teach. Everyone benefits when the teachers are learning too.

Neural therapy began in North America in the mid-1980s with the arrival of an energetic young German immigrant named **Dr. Dietrich Klinghart**. He began teaching two-day courses and has directly or indirectly trained most of those practising neural therapy in North America today. However growth in numbers of trained neural therapists has been slow for two main reasons - **lack of a professional organization** to educate and represent neural therapists and **lack of educational literature in English**.

It is hoped that this conference will be a major step in solving both of these problems. **Our hope is that a North American neural therapy organization will spring out of this conference.** We are also expecting that **three new English-language textbooks** (translated from German) will be released at about that time. The three authors - **Hans Borop, Lorenz Fischer and Stefan Weinshenk** will all be speakers at the conference.

Ottawa is Canada's capital, an attractive mid-size city that is lovely in spring. The conference will coincide with the ["Tulip Festival"](#) where mile after mile of tulips are on display by the canal that runs through the city.

It will also be Canada's 150th birthday with many celebrations planned. The supply of hotel rooms may be limited, so those attending the conference would be wise to reserve rooms early.

Letters:

In reply to the May newsletter about hip pain and depression:

We need to check for liver interference fields in many cases of hip pain as they are common. Also, the presence of two or more interference fields often result from old trauma close to the pain area.

Carlos Chiriboga
Ecuador

Editor's note: Dr Chiriboga is an orthopaedic surgeon.



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NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

I have just returned from attending the **Heidelberg University Neural Therapy Meeting** on July 1st and 2nd and I thought that you might like to know something about it.

The meeting combined a series of **neural therapy workshops** with a **Scientific Symposium**. The workshops were part of Heidelberg University's 60-hour neural therapy program that leads to certification. The Scientific Symposium was a series of lectures mostly on research, some of it recent, and some of it of immediate practical application.

My primary reason for attending was to experience the workshops. As most North American neural therapists know, we have had some excellent teaching over the years mostly from Dietrich Klinghardt and those influenced by him. **However a formal program with systematic teaching leading to accreditation is lacking.** North Americans could develop this, but it would entail a great deal of work, so why re-invent the wheel, if someone else has already done it? The small group of us organizing the [International Neural Therapy conference in Ottawa](#) for May 2017 have been discussing these things.

Now **about the Heidelberg workshops**: About 70 attended, mostly Germans with a few Dutch, Belgians, Italians, Austrians and two North Americans. The lectures and workshops were conducted mostly in English, although sometimes the slides were in German (or vice-versa). I was impressed by how well most Germans and other Europeans speak English.

I attended a variety of workshops and they were mostly well-presented, systematic, clear and interesting. (I have been practising neural therapy for 30 years but I learned something new in each one.) For example, **segmental injections should be intradermal if targeting a dermatome, but subcutaneous if targeting a "vasotome" or myotome.** The "vasotome" concept was new to me and comes from the [segmental anatomy textbook of Ingrid Wancura-Kampik](#), a book written for neural therapists, acupuncturists and manual therapists. A practical example of this distinction is that the dermatome of T12 overlies the vasotome of L5. The depth of the injection will determine which division of the nervous system is affected.

However I was a little surprised at the slowness of the pace at which new ideas were introduced. For example, the first level was entirely about segmental therapy; interference fields were not discussed until more advanced levels, and deep injections are not taught at all. I was even more surprised that energetic testing (autonomic response testing) was not taught. In fact of those present at the conference, only one or two used autonomic response testing in their practices.

The Heidelberg neural therapy committee has made the acceptance of neural therapy into conventional medicine a priority. It feels that it has all the evidence needed to move it



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from the "alternative/complementary" category into the conventional medical realm. Certainly the research reported in this Symposium was conventional, of high quality, and would be more than acceptable in any medical environment.

However the price paid for this policy is that **energy medicine cannot be taught**. It simply is taboo in too many medical circles and for this reason the committee has made the conscious decision to keep it out of their curriculum.

Now **back to the Symposium**: Some of the most interesting lectures revolved around recent research of local anaesthetics. Procaine's action on sodium channels has been known for many years and is the basis of our understanding of its effect on interference fields. Its **anti-inflammatory properties** have also been recognized for over a century, but new science is demonstrating **epigenetic effects**. [Two recent papers](#) show procaine's potential to activate tumor suppressor genes. And these other effects occur at very low concentrations, lower than that needed to block sodium channels.

As [Professor Schaible](#) of Jena, Germany, showed us, **there is still more to learn about sodium channels**. Many can be found in nociceptors. Each has its own depolarization pattern, some fast-acting and of short duration, others slower and longer-lasting. And lidocaine can actually activate heat-sensing sodium channels. Could this be why local anaesthetics momentarily cause pain when they are injected?

And finally, one paper (and subject of a PhD thesis) has finally laid to rest the oft-repeated claim that procaine is dangerous because of its allergic potential. Experienced neural therapists know that **procaine allergy is extremely rare** and this elegant study proved it.

This year's Heidelberg neural therapy meeting was (from my point of view) **most enjoyable**. Heidelberg is a lovely old university town overlooked by an ancient castle. The program was a well-balanced mix of clinical teaching and demonstrations targeting both novices and the experienced, in addition to an interesting variety of scientific lectures. I appreciated the opportunity to converse with world-class scientists (Professors Schaible and Professor Zimmerman) and to spend time with colleagues and keen young students. I would recommend it for next year to anyone wanting to broaden their horizons of neural therapy.

Readers may be interested in some recent papers published by Professor Weinschenk of Heidelberg University. Three of them relate to neural therapy

<http://www.ncbi.nlm.nih.gov/pubmed/27177452>

<http://www.ncbi.nlm.nih.gov/pubmed/26374644>

<http://www.ncbi.nlm.nih.gov/pubmed/23636033>



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

In last month's newsletter I reported a case of a woman with chronic cardiac arrhythmias, unresponsive to medical treatment, who responded to neural therapy of her T6 vertebra. I was pleased to receive an email from **Dr. Pablo Koval** of Argentina commenting on the case. In my opinion, [Dr. Koval is one of the deepest contemporary thinkers about neural therapy](#) (newsletter July 2013) and his book "[Neural therapy and self-organization](#)" is a must-read for all serious neural therapists. His ideas draw extensively from Speransky's work and places it in the modern world of cybernetics and Chaos theory. Dr. Koval is also unique (as far as I know) in his application of Speransky's ideas of the nervous system's tonic (signaling) and trophic (nourishing) functions. This concept becomes part of the correspondence below which he has kindly allowed me to share with you.

Dr. Koval:

"I would like to ask you if the somatic dysfunction of the T6 vertebra (asymmetry and restricted motion) and arcing was **the cause or the consequence**? Do you have a panoramic dental Xray from the patient?"

Editor (me):

I believe the T6 somatic dysfunction was the cause and not the consequence of the arrhythmia for two reasons:

- the response to treatment
- **"Arcing" indicates an "energy cyst"**, i.e. an accumulation of chaotic (or dissonant) energy. This is a concept described by the late John Upledger DO in his book "Craniosacral Therapy". Usually arcing results from trauma, but it can also occur at sites of inflammation or other sources of irritation. The intensity of the arcing is usually proportional to the amount of force absorbed by the organism, so the energy cyst can be conceived of in classical physical terms as potential energy - **like a loaded spring**. The center of the arc does not usually coincide with somatic dysfunctions but in this case it did. Usually somatic dysfunctions result from arcing. Most interference fields do not arc either, or the arcing is so subtle that I cannot feel it.

I did not ask for a panoramic X-ray from this patient, but did check her teeth energetically i.e. by autonomic response testing. Her teeth were for the most part healthy.

Dr Koval:

I don't know about arcing but I think that **a somatic dysfunction must come from something else**. Yes, the patient had two accidents, but the trophic system had time to repair



it. Why didn't that happen?

A somatic dysfunction is like a trigger point - there must be energetic chaos there also. But usually its maintenance over time is a consequence of an interference field that interferes with trophic function.

In my experience dental-oral problems explain 70% of interference fields. (age 18 = wisdom tooth)

I think that it is necessary to wait for the evolution of the patient.

Editor (me):

Your question is thought-provoking (about why the trophic system did not repair the somatic dysfunction). I think that **the reason no healing took place was that there was no "pathology"** (in the classical sense). Somatic dysfunctions, like trigger points are not pathological entities, but rather **dysfunctions**. (I use the analogy of "software problems" vs. "hardware problems". Hardware problems need to be healed; software problems need to be reset or re-programmed.) Similarly, foci (centers) of arcing are accumulations of chaotic energy that the organism must adjust to. They do not provoke an inflammatory response (at least not directly) and therefore cannot be "healed". But they may cause somatic dysfunction nearby or remotely as the organism accommodates an energy imbalance.

Somatic dysfunctions occur for a number of reasons. I see them as being **focal de-compensations of the neuromuscular system**. Most do not cause symptoms; somatic dysfunctions can be found in most "healthy" people. In a typical patient with musculoskeletal pain, a skilled osteopathic physician can find half a dozen or even a dozen somatic dysfunctions. Most are not clinically important and are called **"secondary"**. One or perhaps two or three are **"primary"**. When these are treated the secondary ones generally self-correct. A skilled osteopath knows how to detect the primary ones and treats only these.

Primary somatic dysfunctions usually are the result of trauma, and require only manipulation to be treated successfully. For example a patient may have chronic headaches resulting from a fall on a buttock. The headache is probably coming from a secondary somatic dysfunction in the upper cervical spine, but the primary somatic dysfunction is likely a shear of the sacroiliac joint. Treatment of the upper cervical spine may give temporary relief of the headaches, but only treatment of the sacroiliac joint will cure him or her.

I have long felt that somatic dysfunction can be considered to be a type of interference field. <http://ostemed-dr.contentdm.oclc.org/cdm/fullbrowser/collection/myfirst/id/8711/rv/singleitem>

Somatic dysfunctions may also be secondary to visceral disturbances - so-called **viscerosomatic disturbances**. A common region for this to occur is in the lower thoracic spine, where backache, when it occurs is usually secondary to a stomach or lower esophageal disturbance. Manipulative treatment of the thoracic spine somatic dysfunction will not be successful until the stomach or esophagus is treated. This should be familiar territory for neural therapists who know that visceral disturbances are often interference fields and can be treated with neural therapy. e.g. The patient with mid backache may



respond to neural therapy of the stomach.

And then there are **somatic dysfunctions secondary to classical interference fields** - scars, teeth, autonomic ganglia or other foci of nervous system irritation. **This is where osteopathy and neural therapy intertwine.** You are correct to suspect the T6 somatic dysfunction could be secondary to a wisdom tooth interference field because it, like the heart, sits on the same meridian. And the patient's symptoms began in her teens, without any other precipitating cause in her history.

Yes, we will have to wait for the evolution of the patient. I am sure she will return if her cardiac symptoms resume, but she has now been symptom-free for about six months.

This has been a long answer to a short question, but I hope that it will clarify some of the confusion around this subject. Perhaps we can talk about it some more in Bogota.

Dr Koval:

This a very good ping-pong exercise!

I do not differentiate between trophic and tonic. Both functions go together. For trophism to work well a good tonic function is needed and for tone to work well a good trophic function is required. Actually **health problems are tonic-trophic in nature.** Some are more tonic and others more trophic, but all are tonic-trophic. For sure, trigger points are more dystonic than dystrophic, but they also respond to interference field treatment.

My question (why the trophic repairing function didn't do its work?) could have been stated: why did the tonic-trophic repair function not work?

With regard to this patient, the question in my mind is: when was the starting point? If it was at 18, the accidents had not yet occurred and the date matches with the wisdom teeth. Maybe she has no wisdom teeth at all, but the scars can save information.

The problem treating the consequence instead of the cause is that, **the original problem can manifest itself with a different disease (progressive vicariation).**

I don't know for sure which incident is the cause of the process. Probably you are correct but your case stimulated my interest.

Editor (me):

I learn something from Dr Koval every time I hear him speak or read his writing. I will close our discussion here, but no doubt it will continue at the conference in Bogota, where we both will be speaking.



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May 12-13, 2017: International Neural Therapy Conference in Ottawa, Canada -
<http://internationalneuraltherapy.com/>

Dietrich Klinghardt info@klinghardtacademy.com 908-899-1650

Or see <http://www.klinghardtacademy.com/Seminars-Workshops/>

Dr. Kyu Chung: Workshop on bioenergetic testing for hidden interference fields and agents in addition to procaine in neural therapy.

- LaGuardia, New York, NY.
- For more information WWW.holisticmd.org or call 516-674-9489.

Dr. Michael Gurevich workshop:

- Continuation of 2-year series of workshops by Dr. Uldrich Aldag from Germany, assisted by Dr. Hans Peyer from Switzerland.
- LaGuardia, New York, NY.
- For more information WWW.holisticmd.org or call 516-674-9489



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Volume 11, No. 10, Oct. 2016

NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

Perhaps I am not alone in finding myself forced to come to grips with that all-too-common condition known as "**irritable bowel syndrome**" i.e. abdominal pain and bowel dysfunction of unknown cause. Gastroenterology has never been my favourite subject and for many years my central focus in medicine was the musculoskeletal system. This led me to study orthopaedic medicine, osteopathy, neural therapy, and other methods of direct treatment. However the deeper I dug, the more I found myself confronting gastrointestinal dysfunction and related nutritional, immune and endocrine deficiencies. **Patients just didn't seem to get better without healing the gut.**

So what does this have to do with neural therapy? Readers of this newsletter and [my book](#) will know the emphasis I put on **optimizing general health in order to achieve success in neural therapy**. But the other side of the coin is: **the role of neural therapy in correcting gastrointestinal dysfunction**.

Before writing case histories I usually turn to PubMed for a **literature review**. Using "**irritable-bowel-syndrome**" as search words, I came up with 11,104 items, over 200 published (so far) in 2016 alone - a formidable task to review! The majority of these papers had to do with gut micro biota, use of probiotics, visceral hypersensitivity, immune function, non-celiac gluten sensitivity, etc. - little on the role of the nervous system. However a subset of these papers explored psychological and neurological factors (including the brain) in IBS. A truly excellent (and readable) review entitled [Irritable bowel syndrome: Is it "irritable brain" or "irritable bowel"?](#) discusses this interplay. And in [a thoughtful recent editorial](#) in the Journal of Neurogastroenterological Motility, the whole concept of "functional disorder" in relation to IBS is pondered.

In the research literature, lip service is sometimes given to the role of the autonomic nervous system, but usually in the context of cortical (prefrontal and cingulate gyrus) signals transmitted through the descending tracts. Without downplaying these central influences, **almost nothing is said about reflex modulation of visceral function through local somato-visceral and viscerovisceral reflexes**. And needless to say, **the idea that a scar or tooth could affect autonomic nervous system function** is nowhere to be found. As neural therapists, these are the phenomena that we are interested in.

One exception I stumbled across was [an interesting paper](#) from the urological literature that opened my eyes to research on "**cross-talk**" **between pelvic and other viscera**, e.g. higher incidence of bladder irritability in patients with IBS. It even showed changes in bladder function with dilation of the oesophagus.

Neural therapists should not be surprised by this and should perhaps be reminded in cases of IBS to search for interference fields in other organs, not just scars, teeth and the lower



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gastrointestinal tract. Speransky's experiments in the 1930s explored the autonomic innervation of the whole gastrointestinal tract and helped explain why (for example) an interference field in the anus could possibly cause gastric reflux.

Now about my case report:

A 20-year old male heavy equipment operator presented with **six years of irritable bowel syndrome** beginning with surgery for a ruptured appendix. In addition to bowel complaints he also had stomach bloating and gas, increased urinary frequency and incomplete emptying of his bladder. He also had become tired, lacked stamina and **rated his energy level at 5/10**.

His general examination was unremarkable except for dark circles around his eyes and tight hamstring muscles. Autonomic response testing provoked no response in the abdominal scars, the ileo-coecal region or other abdominal viscera. However **an interference field was detected in the coeliac plexus** and was treated energetically using a Tenscam device. (The classical neural therapy injection of procaine is an easy and safe alternative; - see page 187 of [my book](#)).

Six weeks later he reported more energy and improved bowel movements for a week following treatment; then a relapse as before. By this time his laboratory investigations were available and showed multiple nutritional deficiencies, gluten sensitivity, and probable intestinal candidiasis.

Treatment was directed primarily at eliminating dietary gluten and other food irritants, nutritional support, adrenal support and treatment of intestinal dysbiosis. **Neural therapy was used at times, but in most cases was an adjunct to other therapies.** Over the ensuing year, there was an overall improvement, with many ups and downs. Interference fields were found at various times in his adrenal glands, abdominal scars, coeliac plexus, T10 sympathetic ganglia and anus. A year later his energy was much improved and he was having periods of normal bowel function lasting weeks.

I consider this case to be one in which **the interference field was both a cause and a result** of the associated dysfunctions. Most likely not only the surgery, but also the antibiotic exposure and other stresses, triggered gluten sensitivity and a cascade of gastrointestinal and nutritional problems. Because so many therapies were introduced concurrently, it was difficult to evaluate the role of neural therapy. **At times improvement coincided clearly with neural therapy treatments**, but in my opinion the chief value of neural therapy in these complicated conditions is to provide (with autonomic response testing) a diagnostic framework within which to create a systematic treatment strategy.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

This month I would like to report on the recent **international neural therapy conference in Bogota, Colombia**. This was a major event with close to 500 participants from all over Latin America and Europe. Neural therapists came from as far away as Turkey, but I am sad to say, only three showed up from North America.

This was an excellent conference for many reasons. The program was varied and interesting, the speakers were first rate, and the conference was run smoothly and efficiently. **What impressed me the most however was the spirit of the meeting**. There was an enthusiasm, a collegiality and a friendliness that made everyone feel very welcome. Much of this can be attributed to our hosts. Colombians have a reputation for being warm and friendly people, and this set the tone for the meeting.

However the participants themselves brought a great deal to the conference. The enthusiasm was palpable with the conference-hall full from the beginning to the end of each (sometimes long) day. Despite the many language groups represented (Spanish, German, Portuguese, Turkish, French, English and possibly others) there was a great deal of mixing and friendly chatter. **More than one speaker referred to our common interest of neural therapy creating a big international "family"**.

I could probably fill three newsletters with "pearls" that I took home from the conference - some clinical, some new research, some reassessments of old science, some new perspectives coming from information theory and lots of case studies. However for the purposes of this newsletter **I will pick out a few that were for me personal highlights**.

Lorenz Fischer (from Switzerland) reported on a truly landmark study of neural therapy's efficacy in difficult chronic pain cases. This one study has persuaded the Swiss authorities to include neural therapy within the conventional therapies covered by public medical insurance, i.e. **neural therapy is no longer considered to be "alternative medicine" in Switzerland!**

Laura Pinilla (from Colombia) reported on research into the original writings of Henry Head, the famous 19th century British scientist known for the discovery of "Head zones" or dermatomes corresponding to various internal organs. The concept of pain referring to the skin from disturbed organs has made its mark, but generations of medical students and physicians have been frustrated by the anatomic variability of dermatomes as found in different textbooks. Professor Pinilla discovered that much of this confusion can be explained by how the dermatomes were originally mapped. For example, Head studied dermatomes by responses to pain and temperature; Sherrington's studies used touch.

André Peralta (from Brazil) reported on carotid artery injections of procaine into 2800



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patients over 11 years for treatment of strokes, epilepsy and various other neurological and psychiatric disorders. One of his more interesting observations was induction of rapid eye movements in some of these patients.

Eugenio Andrade (a biophysicist at Colombia National University) presented a fascinating talk on **information in biology**, particularly as it applies to embryogenesis, i.e. how biological forms take shape. He showed evidence that information to create form is not carried by DNA!

Hans Borop (from Germany) presented new research on autonomic nervous system physiology. It seems that the age-old distinctions of sympathetic and parasympathetic systems continue to decline. New microscopic techniques demonstrate parasympathetic nerve fibres reaching everywhere in the body, often following tracts long considered to be sympathetic, e.g. thoracic and lumbar "sympathetic" nerves. And sympathetic fibres are now known to be included in "parasympathetic" tracts, such as the vagus nerves.

David Vinjes (of Spain) spoke on the multiple organ effects of disturbance in the pelvic plexus. Most patients with bowel, bladder or reproductive organ dysfunction have symptoms in more than one organ. Patients presenting with complaints in one organ will not necessarily mention other symptoms and should be questioned about them. (This sounds much like the "cross-talk" I mentioned in last month's newsletter!)

I found it fascinating how **the topics presented often reflected the cultures of the presenters.** For example, the German-speakers presented lectures strongly connected to science and meticulous analytic research. The Spanish-speaking presenters often explored the "big picture" - big ideas, philosophical approaches, and the relationship of neural therapy to the individual and society.

In my opinion both approaches are important and validate the concept of "international meetings". **We learn from each other and the more different our backgrounds the more likely we will discover something new.** The next big international neural therapy meeting will be in Ottawa, May 12-13th 2017, with a day of pre-conference workshops.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

Is neural therapy an alternative/complementary medicine? Or does it belong in "Schulmedizin" (the German term for conventional medicine)?

These questions were raised at a recent IFMANT (International Federation of Medical Associations of Neural Therapy) board meeting in Bogota. The reason for the discussion was that **IFMANT had been invited to be part of a European Union alternative medicine group**. Board members were divided on the subject because **membership implied acceptance of neural therapy's position as an "alternative" form of medicine**.

The question of where neural therapy belongs is not an idle one. The consequences of its position are educational, political and economic, depending on where it is practised. For example, in many jurisdictions where it is considered "alternative medicine" **medical insurance does not cover it**, and the patient is required to pay directly. However in Switzerland neural therapy has recently been classed as conventional and is **now covered by medical insurance**. In Colombia, neural therapy is still considered to be "alternative" but is accepted in the conventional medical system along with homeopathy, osteopathy and Chinese medicine. Training in all four categories leads to specialty designation. In Brazil acupuncture is a recognized medical specialty.

The downside to neural therapy (or any other non-mainstream discipline) being accepted as conventional is that **it then comes under regulatory control**. Regulators can decide who practice, their qualifications and most importantly, fees. In an unfriendly medical environment (as exists in Canada) fees can be set very low and it is illegal to charge more than the government rate, even if paid privately. So **Canadian physicians are happy to provide medical services that are not regulated**, so that they can charge a reasonable fee.

In a perfect world, I suppose **most neural therapists would prefer to see neural therapy within the conventional medical curriculum**. Not only would it become more widely available, but the "alternative medicine barrier" that separates us from our colleagues, would fall. Hopefully a more rational examination of neural therapy would open their eyes to safer and more effective ways of treating their patients. **Ultimately it is our patients who would benefit**.

Letter to the editor:

Thanks for the update on the Bogota conference. I am hoping to make it to Ottawa next spring. Question: **Is anybody talking about IV procaine for treatment of brain injury?** I have been using this approach on a very limited basis with interesting results. I



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mentioned this at the Cranial Academy Conference a couple of years ago and got only blank stares in reply.

Perry M. Perretz, D.O.

USA

My reply:

There were lectures on intravenous procaine at both Heidelberg and Bogota this year, but I don't remember anything specific about its effect on brain injury. Would you like to say something about your experience for the benefit of our readers?

Dr. Perretz:

Of course, I'm happy to share my experience. My practice is focused primarily on the treatment of musculoskeletal pain, but I am residency-trained in physical medicine and rehabilitation, so I have a basic introduction to the treatment of brain injury. I also serve on the board of a newly-created foundation for the promotion of more creative brain injury treatment called BART (Brain Alternative Research Therapies).

I had treated scars with neural therapy for years, as you all have, with great results, and used IV procaine sparingly, for headaches, fibromyalgia, and RSD. I had even investigated the IM procaine protocols of Dr. Aslan, finding the IM shots to be mild cognitive stimulants. One day, working with a man who'd suffered a pretty devastating head injury (and a near-death experience) it dawned upon me that I had neglected to consider using procaine, which penetrates the blood-brain barrier quite well, as a treatment for SCARRING IN THE BRAIN. I rigged a simple **3mL IV push for him with 1% procaine that completely eliminated his headache and his brain fog in under two minutes!** The effects of this infusion may last anywhere from a few hours to as long as a week or two. Seizure activity has been less frequent and less intense with regular infusions.

Such a small dose of procaine has had no ill-effects that I have been able to witness, though there are a very small number of folks that have an allergic aversion to procaine. Lyme patients and other brain fog sufferers appreciate the instantaneous lifting of the veil, too. I assume that the procaine has a membrane-stabilizing effect on the dysfunctional nervous activity in the brain, just as it does elsewhere.

I'd be happy to hear from anyone else using similar approaches.

Perry M. Perretz, D.O.

USA



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear colleagues:

It has always been my hope that this newsletter would be used as a **forum for exchange of experiences and ideas related to neural therapy**. This month I would like to devote the entire issue to an interesting report from a reader (who incidentally I met at the Heidelberg neural therapy conference last July).

Letter:

Since you asked from a prior email, I will give details on a case of **PGAS (Persistent Genital Arousal Syndrome)**: She was a retired professor around late 60 years in age, and had suffered with PGAS since her 30's. Over decades, she had sought out many specialists in the United States and abroad and tried all manner of treatment, without success. She came to me out of curiosity in that she had not seen an osteopath before, and asked if I could help in any way. From her history, I was intrigued that **her symptoms began after a C-section** and she had several C-section scars, one on top of the other. Moreover, the C-section scars were vertical midline scars, not commonly seen today. I had recently returned from the Heidelberg course and suggested that we try neural therapy, to which she agreed heartily.

I injected her midline C-section scar on that first visit with a 30 gauge needle using less than 2ml of 1% **lidocaine**. She called from home a couple of hours afterward exclaiming excitedly that this was the **first relief from the PGAS that she had experienced in 30 years!** She returned two weeks later for another set of injections, and two weeks after that for a third round of injections, each time obtaining partial relief, and she seemed quite happy with that.

However, she cancelled her fourth appointment stating that something conflicted in her schedule, and we have not seen her since.

During the second visit, I had spoken to her that I would write up her case and publish it if any lasting effect be achieved and she was very encouraging. She also stated that I should contribute this treatment to a PGAS support website.

I would like to write something and share it, hoping that neural therapy may help others with PGAS. However, I know neither her outcome nor why she stopped treatment. Were there side effects? Did another medical issue arise? Did she realize that PGAS was better than the absence of it, etc.? So this case is in limbo as far as publishing anything. **Nevertheless, from this one case, I suspect that neural therapy could help other sufferers of PGAS.**

Theodore Jordan DO
USA



My comments:

Fascinating case. I once had an 80 year old female patient who mentioned (incidentally) unwanted sexual feelings in her genitalia but knew nothing about the condition and did not consider looking for an interference field! And I know exactly what you are talking about with the patient's seeming lack of interest in follow-up. I see this quite often, and sometimes wonder what is going through their heads. I have numerous cases in my files of patients with promising responses to neural therapy with whom I lose contact. I collect these as possible case histories for the newsletter, but many never see the light of day.

Now **a few items about PGAD from the literature:** PGAD (formerly called PSAS or Persistent Sexual Arousal Syndrome) as a clinical entity is quite new. It was first described by psychiatrists [Leiblum and Nathan in 2001](#). Since then at least 28 papers have been published. The cause is still unknown, but **associations have been found with withdrawal from SSRIs and SNRIs, restless legs, irritable bladder, anxiety, increased soy intake in diet, small fibre neuropathy and Tarlov cysts.** [Waldinger and Schweitzer](#) suggested renaming the disorder: **Restless Genital Syndrome** because of its overlapping symptoms with restless legs syndrome.

Most of these associations suggest dysfunction at higher levels of the central nervous system. Restless legs are known to be associated with dysfunction in the basal ganglia and substantia nigra. And certainly sexual arousal is a complex process involving temporal and frontal lobes, cingulate gyrus, insula, basal ganglia, amygdala, hippocampus and probably other areas. Nevertheless, **interference fields are known to provoke many complex pathophysiologies, neurological and otherwise.** And as Dr. Jordan has demonstrated, **treating one small nervous system locus of irritation can have profound effects** even on complex processes.

The "take-home" is **always consider interference fields no matter how unusual or rare the medical condition.**



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

Regular readers will know that **in my own practice, neural therapy is frequently intertwined with osteopathy**. Often I find situations where either therapy might be helpful and it is not clear which one to choose.

A recent discussion with **Nicolas Stamer** of Germany (who will be speaking at the [international neural therapy conference](#) in Ottawa in May) made clear to me that I am not alone in this regard. In fact this question will be at least part of what he will discuss in his lecture.

This month I would like to present **a simple case demonstrating this blending of "interference field" and "somatic dysfunction"**:

A vigorous, healthy 64 year-old man presented with **right hip pain that had begun suddenly with a chiropractic manipulation** over a year before. The situation was unusual in that he had sought chiropractic care with no symptoms (at his wife's urging!). The manipulation had been of his low back and was not particularly forceful.

Further chiropractic treatment could not reverse the pain. It was made worse by lying on his right side and it was disturbing his sleep. It was otherwise unaffected by posture or movement. In fact, he played ice-hockey regularly without difficulty.

His health was otherwise good with the exception of "borderline diabetes" (surprising given his slim physique). There was no history of serious trauma. Past surgery included an appendectomy as a child and a left anterior cruciate ligament repair at age 54.

Examination showed full range of motion of his right hip with the exception of **tight hip adductors, slightly tighter hamstrings on the right and a right pubic "downslide"**, i.e. less resistance to gentle caudad pressure on the right pube relative to the left, while supine. **"Arcing"** (a focal pulsation of about 60 cycles/min.) emanated from the right hip region. Craniosacral motion over the sacrum was severely restricted.

The arcing was treated using an osteopathic "unwinding" technique; the right hip adductors and hamstrings released and the pubes were restored to normal balance.

One month later, the patient returned reporting **no improvement, and in fact, a worsening of his pain**.

Neural therapists know that a **worsening of pain after treatment of an interference field indicates that there is another nearby, more important, interference field**. Re-examination of the patient showed the same muscle and pelvic ring imbalances as before,



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and with autonomic response testing a "**therapy localization sign**" (See page 51 of my book <http://www.neuraltherapybook.com/>) on the left side. Further searching revealed an **interference field at the coccyx** that was treated with the Tenscam device, with immediate restoration of blocked regulation.

One month later the patient reported **complete abolition of the hip pain** until a slight recurrence the night before the visit. Again an interference field was found at the coccyx and treated with immediate relief from the pain.

Another month later, he reported no pain at all.

I present this case because **a combination of unilateral tight hip adductor muscles, combined with a pubic "downslip" or "downslide"** (a more modern term would be "inferior pubes") **is an exceedingly common and easily treatable somatic dysfunction.** It is often associated with anterior knee pain, especially in young adolescent girls, but pain may surface in other locations, as in my patient.

Treatment is very simple: With the patient supine on the examining table, the physician passively abducts the affected leg (the side with tight hip adductors) until some resistance is felt. At this point the patient is instructed to gently adduct the leg against resistance (isometric) for a slow count of five. Re-examination should show that the leg can be passively abducted a little farther. Repeat the resisted adduction, several times if necessary, until the leg can be abducted as far as on the opposite side. The position of the pubic bones should normalize and the treatment is then finished.

This treatment is almost always effective and does not need to be repeated. In my patient's case, the failure of osteopathic treatment, and in fact, the patient's worsening was totally unexpected. **This was a distinct wake-up call that a nearby interference field needed to be found and to be treated.**

This lesson can be generalized to other **failures of manual treatment.** Always look for an interference field if the treatment does not succeed.

The same can be said for failures of neural therapy. Another interference field or a somatic dysfunction is likely nearby. This is particularly important in the head where cranial somatic dysfunction is difficult to treat with procaine injections. Even the Tenscam (an energetic device) does not treat some cranial somatic dysfunctions as well as the hands do.

Letter:

Please let me describe a recent case of PGAS (persistent genital arousal syndrome) in a 63 year old women. Her condition had begun five years previously and required orgasm (by self-stimulation) for relief. Her symptoms often occurred at inopportune times while in public places and needed orgasm for relief. Her husband was unaware of her situation.

There was a long history of past and present emotional trauma including caring for a



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severely disabled grandchild.

Autonomic response testing revealed blocked regulation by mercury from eight dental amalgam fillings. Interference fields were found in the lumbar ganglia and treated with intravenous procaine and nasal lidocaine sprays. She was referred for treatment of unresolved emotional conflicts/trauma by psychotherapy and EMDR (eye movement desensitization). Hypothyroidism, gluten/casein sensitivity, intestinal dysbiosis and nutrient deficiencies were treated.

A complicated, but rewarding case and now symptom-free!

Rob Banner MD
Canada



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

This month I would like to present an interesting case of "shortness of breath". "Shortness of breath" can mean a lot of things, but in this instance my 28 year-old female patient meant that she was experiencing something closer to **"air hunger" - or a feeling of being unable to take in enough air with a normal inspiration.** In addition, she was yawning excessively and felt tightness around her throat.

Her symptoms had begun suddenly 9 months before and were alarming enough that she had gone to the local Emergency Department. Investigations including x-rays, electrocardiogram, blood tests and arterial oxygen pressure were all normal.

There was no preceding history of trauma, dental work or vaccination, but **she had been under considerable personal stress.** She was aware that she was **clenching her teeth at night.** She was otherwise very healthy, exercised regularly and had been on a gluten-free diet for 14 years.

"Air hunger" is not in my experience a rare complaint, although seldom is it the patient's main reason for consultation. **Often there is a history of "being winded"**, i.e. suddenly being unable to breathe after a blow to the midriff or a fall on the back. The trauma may have occurred many years before, even in childhood. **With this history, the respiratory diaphragm is usually tight**, i.e. it does not release fully on expiration, and the respiratory volume is reduced.

Other than spirometry, I cannot think of any simple way to diagnose a tight diaphragm. However using osteopathic technique, **one can usually feel "arcing" or a subtle pulsation of about 60 cpm emanating from the diaphragm.** "Unwinding" the diaphragm, i.e. placing opposing hands on the anterior and posterior trunk while the patient is supine and waiting for a release usually cures the condition in one treatment. The whole body relaxes and chronic headache or backache may subside, or at least be easier to treat.

I have never tried this, but quaddles of dilute local anaesthetic around the trunk might achieve the same effect. (Readers' comments are welcome!)

In my patient's case no arcing could be felt in the diaphragm and the only abnormality I could find was tightness of the temporal and facial bones, consistent with **chronic facial muscle tension and clenching of the teeth.** This was treated using osteopathic technique. A search was made for interference fields using autonomic response testing in the viscera (including the lungs), the teeth, tonsils and cervical ganglia (because of the tightness around her throat), but nothing was found.

On a second visit two months later, there had been no change in her shortness of breath. This time I used an **Ayurvedic technique** taught me by my friend and colleague Carlos Chiriboga of Ecuador. See Vol.6 No.2 of (<http://www.neuraltherapybook.com/newsletters/>). Strong pulses were found in all the areas corresponding to the right side of her body; **no pulse was found on the left side**



corresponding to the left head, neck and upper trunk. This meant that an interference field was to be found in the left upper third of the body. A careful examination of tonsils, cranial ganglia, lung and vaccination sites using autonomic response testing, produced nothing. However a re-assessment of the teeth (I had checked them on her first visit) showed **an interference field at tooth 2.5** (tooth 13 in the American system). The tooth appeared in perfect health but was crowded by the adjacent tooth at 2.4 (12). **Energetic neural therapy using the Tenscam device abolished the interference field in the tooth**, but autonomic regulation was still blocked. (See Chapter 5 of my book on [neural therapy](#).) The temporal bones were externally rotated and nearly immobile, likely indicating chronic clenching due to anxiety. This was treated using an osteopathic technique and normal autonomic regulation was restored.

The response was immediate relief of the "air hunger" and relaxation in the throat muscles - to the delight of the patient. This lasted three weeks; the tooth was re-treated and again a good response was obtained.

The key to explaining this response was the location of tooth 2.5 on an acupuncture meridian associated with the lung. The tooth was in perfect health, but somewhat crowded by an adjacent tooth. The patient, who was living with personal stress, was clenching and putting excessive pressure on the vulnerable tooth, creating an interference field.

"Air hunger" is an unusual primary complaint and is usually caused by a tight respiratory diaphragm, which can be treated easily with osteopathic manipulation. However in this case the air hunger was caused by an interference field in a second bicuspid (2.5 or 13 in the American system), disturbing energy flow in an acupuncture meridian shared by the lung. **The interference field was created by a combination of mechanical crowding of the tooth exacerbated by excessive clenching of the teeth.**



Volume 12, No. 4, Apr. 2017

NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

This month I would like to **revisit the subject of autonomic response testing or ART**. For those readers not yet familiar with the term, I have devoted a full chapter to it in my book: [Neural therapy: Applied neurophysiology and other topics](#). ART is a tool in physical examination that can apply to many areas of medicine and particularly to neural therapy and osteopathy.

In essence **ART searches out the locations in the body that are under stress, or have been under stress in the past (tissue memory)**. Presumably in these locations, heightened (local) sympathetic tone is present, as if the nervous system is "on guard" against further threat. **When the examiner's hand approaches the vulnerable spot**, (perhaps a scar, an infected tooth, or a somatic dysfunction) **the whole autonomic nervous system responds**. The response can be observed by a change in pupil size, a change in heart rate or pulse amplitude, a change in indicator muscle tone, etc.

Since the technique depends on observing a sympathetic response, **it is important that the patient's body is not already in a state of heightened sympathetic tone**. This can occur when the patient is unwell, or is under physical or emotional stress. The chapter in my book outlines methods to overcome these "blocks" and to achieve "open" (or "unblocked") regulation. In open regulation, the autonomic nervous system is parasympathetic-dominant, in a relaxed condition, and (in terms of oriental medicine) in a yin state.

The advantage of being in this state for ART, is that **the body is much more responsive to any stimulation because the sympathetic "noise" is at a minimum**. Every effort should be made to achieve this state when searching for interference fields. However sometimes an inordinate amount of effort is required and valuable time is expended.

This is when a "**short-cut**" is needed - something that will quickly put the patient into a relaxed, yin state. No doubt acupuncturists have their methods, and perhaps others, including hypnotists do, too. I would like to suggest a couple of methods that are quick and easy to learn.

This first comes from osteopathy and is a tried and true "shotgun" method of treating all sorts of somatic dysfunction anywhere in the body. It is called the **CV4**, referring to a method of supposedly compressing the fourth ventricle of the cerebrospinal fluid system. The classical understanding of how it works is to "**pump**" **the cerebrospinal fluid**, thereby clearing mechanical restrictions in the spine and brain.

The technique requires the patient to lie supine with the physician sitting at the head of the examining table and his or her hands cupped under the occiput. The weight of the skull rests on the physician's thenar eminences that are positioned bilaterally under the slight



depressions superior to the nuchal ridge. **After a minute or two a softening in the tissues will be sensed, the patient's breathing will become shallow and re-testing will confirm that the patient is now regulating.** (for a more detailed description and explanation of this technique see pp.110-115 of [Magoun's Osteopathy in the Cranial Field](#)).

A second method, even more reliably effective, is what I call a **CV2**. Here with the patient supine and the physician seated at the head of the examining table, the operator places his or her thumb-tips lightly on the scalp 1 cm apart and on both sides of the midline, perhaps 1 cm posterior to bregma (or the junction of the saggital and coronal sutures. The second, third and fourth fingers of each hand rest lightly on the upper temples. **The thumbs and fingertips in these positions are "cradling" the first and second ventricles.**

Next, the physician feels for a very subtle movement of the thumbs together in an anterior or posterior direction, with the fingertips rotating in the opposite direction for up to 30 seconds. Then there is a pause of a few seconds, and the thumbs (and fingers) move together in the opposite direction. This continues as a very slow back and forth rocking movement, taking about 1 minute per cycle (much slower than the craniosacral or primary respiratory rhythm). Sometimes the thumbs do not move precisely together, one dragging behind the other or with a shorter amplitude per cycle. Asymmetry of movement indicates mechanical restriction of the cranial contents. This does not need to be treated at this time.

Once the physician has "tuned in" to this movement, the movement on one side is resisted, while the other is allowed to continue as before. The side that is held can even be encouraged to move in the opposite direction, creating an oscillation where the two sides of the head (brain) are oscillating in opposite directions. Only one or two of these oscillations will put the body into a still point, i.e. a parasympathetic-dominant yin state.

These techniques take a little practice, but are real time-savers in achieving a "regulating" state. **Searches for interference fields or testing for systemic causes for blocked regulation are much more accurate and efficient when starting from a regulated state.**



Volume 12, No. 5, May 2017

NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

Ever since Ferdinand Huneke's "Eureka" moment in 1941, when injecting a leg scar with procaine cured a chronic contralateral frozen shoulder, the concept of the "interference field" has been central to neural therapy. And to a large extent it has been mysterious. What is the connection between an interference field and a symptom, so often in a remote area of the body?

Readers who are familiar with my teaching and writing know that I have been pre-occupied for a long time with the factors that activate an interference field, or make it more or less responsive to treatment. The second half of my book *Neural therapy: Applied neurophysiology and other topics* is devoted mainly to this subject.

However, this month I want to look at this subject by posing a different question: How can the same symptom be triggered by different interference fields? Experienced neural therapists no doubt see this frequently, but this phenomenon is not often reported because it is observed only over a considerable length of time. Most case reports of interference fields describe a response to treatment of a single interference field over a relatively short period of time. Time is needed to see symptoms return.

Let me present this case as an example:

A 50 year old woman presented with left knee pain and swelling of both legs (worse on the left) of about three months duration. The onset of pain was preceded by a fall on her left knee several weeks before. Chiropractic assessment, X-rays and treatment two or three times a week had afforded her only a little relief.

Oedema+++ was present in both legs; the pelvis was symmetric and the sacroiliac joints stable but the right hip adductor muscles were tighter than on the left side. Because of the several weeks long latent period between the injury and the onset of symptoms, an interference field was searched for using autonomic response testing. This was found in a tubal ligation scar and treated energetically with a Tenscam device.

The patient reported that by the next day she could feel a change and two weeks later there was almost no pain. However some swelling persisted and the right hip adductor muscles were still tight and were manipulated. Another interference field was detected at the L2-L3 interspinous space (site of a previous epidural injection) and treated using the Tenscam device.

Her response was good and I did not see her again until 7 months later when she presented with upper body pain - neck and back, as well as recurrence of leg pain and swelling, much as before. This had been preceded by cataract surgery of both eyes a month apart. She also complained that her right eye vision had deteriorated. This time an interference field was detected "off the body" about 12 inches (30 cm.) anterior-inferior to the right eye.



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For neural therapy and advanced healing



(Off-body interference fields require energetic techniques both for detection and treatment.) In this case it was treated with the Tenscam device and within one or two days all pain had shifted to the lower half of the body with a distribution much as before.

A month later an interference field was detected in her liver. This came as no surprise when she admitted to a recent increase in her wine consumption and taking too much Tylenol. It is also possible that the eye surgery had contributed to the liver interference field. In any case the liver was treated with the Tenscam device; the patient discontinued alcohol and Tylenol and her lower body symptoms settled quickly and lastingly (for 1 1/2 years) when I saw her again, this time with tight right hip adductors and an interference field at the pubic symphysis. This was treated but the patient was then lost to follow-up.

In summary, my patient presented with knee pain and leg swelling multiple times over a period of two years. Interference fields that with treatment relieved these symptoms, included a tubal ligation scar, an epidural scar, and the liver.

The solution to the mystery of how one symptom (or group of symptoms) can be caused by different interference fields at different times lie in the animal experiments of Speransky and his discovery of "tissue memory". See newsletter Vol.7, No.1, 2012. Once a tissue memory is established, irritation anywhere in the nervous system can cause the memory to be re-activated.

This is commonplace in medical practice. Patients who experience recurring headaches can have the same headache triggered by a variety of stimulants - a change in barometric pressure, stress, a somatic dysfunction anywhere in the body, a viral infection, a scar or perhaps even a dental problem.

The point to remember in neural therapy is that even when an interference field has been found to cause a certain symptom and been treated successfully, a recurrence of the symptom may be caused by something totally different.

Third Heidelberg Neural Therapy Conference.



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Volume 12, No. 6, June 2017

NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

Almost a month has passed since the **first International Neural therapy conference in North America** (in Ottawa, May 11-13, 2017). Many observed it to have been **an historic event**, very successful by any measure, and memorable for a number of reasons.

The organizers of this event were a small group of Canadian and American physicians (**Robert Banner MD** of London, ON, **Michael Gurevich MD** of Glen Head, NY, **Richard Nahas MD** of Ottawa, ON, and myself) who felt that a neural therapy organization in North America is badly needed.

It is needed because **neural therapists are scattered across North America** with varying levels of training and skill and virtually no contact with each other. In fact finding those who practice neural therapy has proven to be difficult.

It was also felt that the best way to "tease out" neural therapists was to offer an international conference, featuring high quality speakers with name recognition. So **we created a "wish list" of speakers** with the hope that if we were able to invite even a few, we would have a good conference. To our surprise, **every single speaker on the list accepted**, (with one exception: North America's own Dietrich Klinghardt who unfortunately had other commitments).

However the list contained the contemporary giants of neural therapy: two authors of neural therapy textbooks, academics, teachers, presidents of national organizations and others who have contributed to neural therapy at an international level in many ways. As a result the conference program was a smorgasbord of subjects ranging from hard science to the art of physical diagnosis, and from medical philosophy to the nuts and bolts of clinical practice.

To our surprise, the workshops were major attractions and were filled to capacity, with some registrants turned away. **Clearly there is a hunger for good practical teaching in North America.**

The organizers' goal was that this should be an international conference of not only speakers but also registrants. It was therefore a source of great satisfaction that registrations came from as far away as New Zealand and Pakistan. 17 countries in all were represented.

The conference began with a lecture by **Dr Hans Barop**, author of one of the most respected neural therapy textbooks (currently undergoing translation into English), and president of the German neural therapy society. Dr Barop clearly loves anatomy and neurophysiology and has made it his mission to explore and integrate old (early 1900s) and new literature. His lecture was rich in new information, but for me a highlight was his spot-lighting of **"functional and structural neuroplasticity" as a basis of chronic disease - and evidence that neural therapy**



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can correct it.

Dr Barop's colleague and friend **Lorenz Fischer** from Switzerland followed with a lecture on neurophysiological and clinical research into neural therapy. Professor Fischer is a tireless teacher and researcher, who has through his own work persuaded the Swiss medical authorities to include neural therapy in the conventional medical armamentarium, i.e. **Neural therapy is not considered to be "alternative" to standard medicine in Switzerland, but rather part of it.** He has done this through some powerful clinical studies of his own and also **by demonstrating the positive financial and patient-satisfaction profile of neural therapy as compared to standard treatments.**

Our next speaker was **Dr Laura Pinilla** of Colombia, an academic, a researcher and president of the Colombian Association of Neural Therapy. Dr Pinilla's research has included in-depth **study of the great neuro-scientific themes of the 19th and 20th centuries.** Rather than dismissing these ideas as archaic and now irrelevant, she has brought them forward and **incorporated them into current concepts of non-linear neuro-physiology.** This synthetic approach, as opposed to the analytic approach of most contemporary neuroscience, raises profound questions about our whole system of diagnosis. In Dr. Pinilla's view, neural therapy opens our eyes to **"A new way of reasoning in medicine!"** - a thought-provoking and stimulating lecture.

The last lecturer of the first morning was **Dr Mark McClure**, of Washington D.C., a dentist and one of the most experienced neural therapists in North America. As a biological dentist, he emphasized the phenomenon of sites of inflammation, especially periodontal areas, to be **"toxic dump sites"** where mercury and other toxins tend to precipitate.



Volume 12, No. 7, July 2017

NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

Last month I promised to continue my report ([Vol.12, No.6](#)) on the First International Neural Therapy conference in North America (held in Ottawa, Canada on May 11-13th). The first morning's lectures set a high standard that was maintained throughout the rest of the conference.

The first afternoon's lecture was by our one non-physician, non-dentist guest: **Jim Oschman** PhD. Dr Oschman is a scientist whose lecture began with the statement that "**inflammation is an energetic condition**". With inflammation comes an excess of positively charged free radicals that can only be neutralized by electrons ("the ultimate anti-oxidant"). Walled-off inflammation cannot be penetrated by conventional medicine but is susceptible to energy. A great un-tapped reservoir is the earth beneath us. Walking barefoot reduces inflammation in the body. In addition, Dr Oschman posited that procaine's anti-inflammatory properties may be related to its facilitation of electron flow through inflammatory barriers.

Dr Kyu Chung presented elegant techniques of detecting interference fields and prioritizing them, using methods from applied kinesiology and auricular medicine.

Dr Michael Gurevich challenged the old idea that neural therapy should be avoided in psychiatric patients. He presented a number of cases in which psychiatric patients with life-long disabilities were dramatically cured by releasing unresolved emotions bound in scars and other interference fields.

Among **Dr. Nicolas Stamer's** special interests is the connection between interference fields and mechanics, particularly of the head and neck. He demonstrated that interference fields of the "gut of the head" (sinuses, tonsils, teeth, etc.) can be detected by careful examination of neck musculature. He also presented research on the specific cytokines emanating from dental infections, root canals and cavitations.

Dr Armin Reimer drew attention to the importance of the ganglia in autonomic nervous system physiology and the importance of their treatment in effective neural therapy.

Dr Eduardo Beltran's lecture on "Biological Communication Systems" demonstrated that the central nervous system is only one of many ways in which the body communicates with itself. Beyond the long-recognized systems such as circulation of blood and lymph, lie energetic communications through semi-conductor tissues, the microtubule system, quantum communications, the acupuncture channels, etc. Neural therapy's action is probably to open "biological communication switches".



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Dr Richard Nahas presented a synthesis of ideas to illustrate his novel theory of vibrational medicine, linking collagen to the autonomic nervous system and to the acupuncture meridians of Chinese medicine. He challenged the audience with the suggestion that neural therapy is in fact one of the purest applications of a new paradigm of medicine, based not on treating diagnoses but on removing obstacles to healing.

Dr. Carlos Chiriboga, an orthopaedic surgeon, demonstrated in a dramatic way how combining autologous stem cells with neural therapy was able to restore not only joint structure but also joint function in a severely damaged ankle.

Dr Gerasimos Papathanasiou updated us on the increasing body of knowledge linking the nervous, immune and endocrine systems. In his view, the interference field is a silent focus of inflammation with its own "inflammatory profile" - different from patient to patient and probably different in the same patient over the course of time. The signaling from interference fields in multiple ways shifts the organism into a chronic imbalance of its regulatory systems.

Dr. David Vinhes' charming talk reminded us of the importance of the **art of medicine** in diagnosing interference fields. In a beautiful series of slides, slight changes of skin colour or even skin blemishes were shown to point to otherwise hidden interference fields.

Dr Phil Mollica is known as one of the foremost exponents and teachers of the use of ozone in dentistry. His lecture demonstrated how he incorporates neural therapy into the most difficult and complex surgical problems, including chronic infections, trauma and cancer.

(AV recordings of [these outstanding lectures are now ready](#). I am personally looking forward to reviewing them.)

The conference concluded with an informal gathering of those interested in forming a North American association of neural therapy. We (the conference organizers) were delighted to see the enthusiasm and the number of highly qualified participants who stepped forward to volunteer their services.

A founding meeting of those interested is being organized in a central location (probably Chicago) in the fall. The first step will be to create a founding board. Next will be to choose an executive, write a constitution and by-laws, solicit members and plan another conference. Keep posted and we will let you know what happens!

Neural therapy conferences and workshops:

World Congress in Complementary/Alternative Medicine

(including neural therapy) August 31st to September 2nd, 2017 in Cartagena, Colombia.
This major event is expected to attract 1500 physicians from around the world.

[Intermediate - Advanced Neural therapy workshop:](#)



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Ralf Oettmeier, Switzerland
La Guardia Marriot Hotel in Queens, New York
Nov. 17-19, 2107
Organized by Dr. Michael Gurevich

Introductory Neural therapy workshop:

David Vinjes MD, Barcelona, Spain
LaGuardia Marriot Hotel in Queens, New York
Dec. 1-3, 2017
Organized by Dr. Michael Gurevich



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

I find **dizziness to be a difficult symptom to diagnose**. There are simply so many causes. And because symptoms often come and go, the cause of dizziness is hard to pin down and response to treatment is challenging.

Many years ago as a pre-med student, I had the good fortune to spend several summers in aviation medical research labs: two summers at McGill University and another at the Karolinska Institute in Stockholm, Sweden. At that time the McGill lab's main focus was the neurophysiology of balance. The lab director was a former test pilot who had personal experience of the tricks that high-speed acceleration can play on the body's nervous system.

It was a wonderful period of my life, but I think the most important lesson I learned was that **balance is more than just balance organs. Balance is determined by three neurological inputs: the balance organs, the eyes, and the musculature of the upper neck**. The function of the balance organs is self-evident; the eyes function to monitor the visual horizon; and the neck's job is to provide a level platform for the vestibular apparatus and the eyes. (Of course the neck musculature is intimately connected with postural muscles everywhere in the body.)

Years later, I was able to apply some of this knowledge clinically when I began to study and practise osteopathy. The muscles of the upper neck are extremely important in body posture and balance. Dysfunction can lead to (among other things) disturbance of balance. And yes, **manipulative treatment can make a difference**.

The world of neural therapy opens our eyes to even more possibilities. As [Professor Beltran](#) outlined in his lecture at the [Ottawa neural therapy conference](#), there are numerous communication systems in the body beyond the central nervous system. **Interference fields can disturb balance in many ways, but probably none so directly as when they are found in upper wisdom teeth, or their scars**.

Sometimes the relationship with balance is direct and simple; other times the relationships are complex. Here is a case in point:

A 61 year-old man presented with 2 ½ years of intermittent vertigo and tinnitus. Episodes came without warning; when severe they were accompanied by vomiting; the tinnitus was bilateral but worse on the right side. During bad stretches he had attacks almost every day. A normally vigorous man, his energy had dropped significantly since the onset of these symptoms.

Generally speaking he was healthy with no serious illness or trauma in his past. He had



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*been taking medication for hypertension for many years and a statin drug for hypercholesterolemia. However, he had had **all his upper teeth extracted not long before the onset of his symptoms** and he wondered if there were a connection. He found his denture uncomfortable and hard to tolerate.*

*On examination there was no significant disturbance of his mechanics in the head, neck or anywhere in his body. However with autonomic response testing (ART) **an interference field was detected at tooth space 1.8** (right upper wisdom tooth). There was also a resonance with dental infection homeopathics indicating chronic infection. Treatment was by the Tenscam device using the ultraviolet frequency (bactericidal for dental pathogens). Three treatments over eleven days resulted in **complete remission of all symptoms for about one year.***

***His symptoms returned** suddenly after riding an all-terrain vehicle over rough ground. No interference field could be detected in the tooth space, but his **neck and his right sacroiliac joint mechanics were disturbed**. In addition, **an interference field was found in his right tonsil**. The mechanical disturbances were treated using osteopathic manipulation and the interference field was treated with the Tenscam. Five days later he reported that his symptoms had worsened. An interference field was detected this time on the opposite (left) side and treated. Again there was little improvement, but **this time the old (tooth space 1.8) interference field declared itself** and was treated with the Tenscam. A few days later, the attacks subsided and he is now (nine months later) symptom free.*

This case is interesting for more than one reason. What I found most intriguing was **the mechanical disturbance acting as a "second blow"** (Speransky's term), and reawakening the dental interference field. Tonsils lie adjacent to the superior cervical ganglia and interference fields here often indicate mechanical disturbance in the neck and head. I imagine what happened was **neurological summation of mechanical inputs with "tissue memory" of the dental infection and the related vertigo and tinnitus.**



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

Neural therapy has a place in treating many medical conditions, but I doubt many of us would consider it a first option when dealing with fatigue. Fatigue is just too nebulous and multifactorial a symptom to expect the simple solutions that we hope to obtain from procaine injections.

Not that fatigue is unimportant - it is often the "elephant in the room", not brought up unless asked about, yet a sign of deeper problems in the patient's health. These are the problems (malnutrition, toxicity, allergy, emotional problems, etc.) that can defeat the most skillful neural therapist if not addressed.

Fatigue is a big part of my practice. My patients generally have chronic conditions for which they have already sought medical care with little success. If they weren't in trouble beforehand, they certainly were after being treated conventionally for any length of time. **Anti-depressants, ant-inflammatories, stomach acid suppressants, etc. are one-way tickets to poor health which includes fatigue.**

But then there are exceptions: **A vigorous, generally-healthy 62 year old man (whom I knew well) presented with fatigue of three months duration.** He was fit, physically very active and an outdoorsman, so fatigue was unusual for him. He reported that he "could sleep anytime" and was waking in the mornings feeling un-refreshed. His fatigue had begun during maple-syrup making time, a few weeks in the early spring of heavy work, long days and little sleep. He felt that he had been "burned out" and had simply not recovered.

His appetite was good; there had been no change in his weight and no other symptoms suggesting serious illness. On examination he appeared very healthy and his general examination was unremarkable except for **two interesting findings**. One was a **weak "Vatta" pulse on the right side**. A weak "Vatta" pulse indicates an interference field in the upper third of the body on the same side. (See [newsletter Vol.6, No.2](#)). The second finding was a **"Therapy Localization sign"** on the left, indicating an important interference field somewhere in the body. It does not have to be on the same side. (See page 51 of [my book](#).)

These findings meant that I could with confidence know that an important interference field would be found in the right lung, upper shoulder, neck or head on the right side. And sure enough, with autonomic response testing **an interference field was found in tooth 1.6** (the first upper molar) that could be matched with the Therapy Localization sign. Moreover, when challenged with the presence of dental infection homeopathic nosodes, there was a strengthening of the indicator muscle, denoting a **(silent) infection of the tooth**. See [newsletter Vol.4 No. 10](#). This was treated using the ultraviolet function of the



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Tenscam. (Procaine injection with an appropriate homeopathic would no doubt have achieved the same result.)

Two days later, the patient reported that for the first time he could "feel something in the tooth". No interference field was detected with autonomic response testing and no treatment was given. A week later, the patient was regulating and again no interference field was found.

Because **tooth 1.6 is on an acupuncture meridian connected with the thyroid**, and my patient's only complaint was fatigue, I ordered a serum TSH at this point. The TSH level was 2.37 - not elevated by many physicians' standards, but possibly significant and possibly lower than before he was treated.

Two months later (and after only one treatment) the patient reported that his fatigue had disappeared and he was feeling well.

This was certainly not a dramatic case of **hypothyroidism, but I have learned to look for the mild cases as well.** Although many labs consider TSH below 5 acceptable and the American Endocrinology Association makes it's cut-off 2.5, I find many mild cases with even lower TSH levels. In fact I generally aim for my patient's TSH to be 1.5 or lower.

Happily in this case I did not need to make the decision on whether to treat with thyroid supplementation or not, as the patient's own regulation corrected his fatigue.

Just after writing this report, I noticed that I have already written on this topic once before - ten years ago in [newsletter Vol.2, No.3](#). Yes, **let's keep considering neural therapy's applications, even in unlikely conditions like fatigue!**



Dr. Robert F Kidd, MD newsletter archive
For neural therapy and advanced healing



Volume 12, No. 11, Nov 2017

NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

This month I want to explore **the relationship between neural therapy and psychiatry**. The relationship is complicated. The "bible" of neural therapy, at least in the English-speaking world (Dosch's Manual of Neural Therapy According to Huneke: 2nd English edition) states clearly that **neural therapy is not indicated for: (a) mental disorders and (b) psychogenic disorders** (p. 59), with a few exceptions.

This teaching has left neural therapists wary of exploring psychiatric illness, quite apart from the natural reticence that many physicians feel when dealing with unpredictable patients

Most of us are aware of a psychological component of interference fields and sometimes see emotional releases with physical treatment, e.g. procaine injections. **Dr. Klinghardt's teaching has demonstrated that unresolved emotional conflicts can be the key factor in interference fields.** (See Chapter 11 of [my book](#).)

However treatment of true psychiatric illness by neural therapy is another matter. This month I would like to draw attention to the work of my friend and colleague **Dr, Michael Gurevich MD**, a New York psychiatrist and one of the most innovative neural therapists in the world today.

Dr Gurevich immigrated to the US from his native Lithuania in the early 1980s. He trained in the US in psychiatry and has been in practice for close to 30 years. From this start, **I was puzzled by how he found his way from psychiatry to neural therapy** - two so seemingly different disciplines. So I asked him, and here is the story:

Dr. Gurevich's first break from mainstream psychiatry was to explore the use of acupuncture in substance-abuse patients. This led to study of other non-conventional techniques such as guided imagery, eye-movement desensitization, yoga and eventually functional medicine.

Then in 2002 he met Dietrich Klinghardt during a family constellation workshop. **Dr. Klinghardt introduced him to neural therapy and he was immediately "hooked"!**(Dr. Gurevich's words).

Dr Gurevich began to study neural therapy and autonomic response testing intensively. However **he missed the part about psychiatric illness being a contraindication to neural therapy** and began to find applications even to quite mentally ill patients. As we will see, he was able to achieve some remarkable successes, - true breakthroughs in our understanding and treatment of psychiatric illness.

Those who attended the First International Neural Therapy Conference in North America in



Ottawa will remember **Dr. Gurevich's excellent lecture**. (The AV of the conference is [still available for purchase](#).) Recently **Dr. Gurevich also had [an article on a similar topic](#) published in the Townsend Letter**.

Dr Gurevich's enthusiasm for neural therapy is infectious and he is generous to share his energy with others. Over the last few years he has organized and hosted a series of workshops in New York bringing high-quality neural therapy teaching from various teachers including **Jeff Harris of Seattle** (twice), **Uli Aldag of Berlin** (six times), **Hans Peyer of Switzerland** (three times) and in the near future **David Vinyes of Barcelona** and **Ralf Oetmeier of Switzerland**.

Typically 25 to 30 physicians attended each workshop. This has lead to **a considerable number of well-trained and enthusiastic neural therapists** in North America. Many of these are now founding members of the newly created North American Academy of Neural Therapy. (See [last month's newsletter](#).)

Dr Gurevich was not only an organizer of the Ottawa conference, but is also a founder of the North American Academy of Neural Therapy and is now its first treasurer. **He is truly a driving force behind this long-awaited arrival of neural therapy as a serious discipline** in North American medicine. And **a pioneer in North American (and world) psychiatry!**

Founding Members!

This is your opportunity to become a founding member of the North American Academy of Neural Therapy.

And to help launch this new organization. Already 10 have signed up!

Send your cheque of \$1000 to Dr. Michael Gurevich, Treasurer NAANT attention Dr. Michael I. Gurevich, 997Glen Cove Avenue, [Glen Head, NY 11545, USA](#).

Lots of letters this month!

Dear Robert,

Congratulations for creating the North Academy of Neural Therapy... It is a seed and all of us will have to take care of it.

To clarify, IFMANT is only for MDs, not for dentists. In your newsletter you said that IFMANT is for dentists also.

Please, remember that my name is Vinyes, not Vinjes.

I'm very happy with the foundation of this NA association... you know that we'll be there to help you, with love.

David Vinyes,
Barcelona



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For neural therapy and advanced healing*



Dear Dr. Kidd,

I send my congratulations (twice) to you and your colleagues, because of the formation of the North American Academy of Neural Therapy.

About diabetic foot and Charcot foot, I can say that in my experience surgery was avoided in 60% of cases of diabetic feet ready for amputation. Diabetic foot is a trophic and tonic disturbance and one of the most important expressions of dystrophic-dystonic disorders.

Pablo R. Koval
Argentina





Necrosis posoperatoria



Dear Dr. Kidd,

With regard to the diabetic foot, if we combine neural therapy with ozone therapy the results will be much better. If with both there is still no improvement, you have to use PRP (platelet-rich-plasma) in combination with ozone, plus IV nutrient therapy.

Leanne Astawan
Canada

Hi Robert,

For the treatment diabetic neuropathy, arthropathy and lymphedema: I treat the femoral artery and track the cutaneous nerves involved, down the leg, and do an interference field search, treating everything with procaine above the lymphedema, if it's present. Also, make sure the blood sugar is stabilized usually by Alpha-R-Lipoic Acid, Chromium, Vanadium and herbal combinations Gymnema Selvestre and others. Also, hot and cold foot baths have helped the circulation and mobilization of the toxic lymph accumulation. So far, I have a 100% rate of effectiveness preventing loss of foot and treatment of diabetic ulcers. The pain associated with arthropathy about 60-75%, neuropathy 60-75% and lymphedema 90%.

Jeff Harris, ND
USA



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Dear Dr Kidd,

I was surprised to see:

"anyone with adequate medical training who was licensed to inject could be Regular Members. This would include MDs, American-trained DOs, dentists, veterinarians and naturopaths (from jurisdictions permitting injections)."

Doesn't include Nurse Practitioners as one of the profession. Is this an oversight?
Thank you,

Sevgi Ercan

Good morning Dr. Kidd,

You did not mention whether Nurse Practitioners can become members?
Thank you,

Irina Serebryakova, NP
www.GrotonWellness.com

Very disappointed Doctors of Chiropractic was left out of your elite group considering the fact that DC's played a large role in your testing protocols and support your efforts.....

Gary Noseworthy, DC

These are good questions, but the answers are complicated. For sake of space, I will respond to these letters in the next newsletter (December 2017)

AV Films of the [First International Neural Therapy Conference](#) of North America (May 11-13, 2017) are now available. There are two:

- [The conference itself](#) - Available in English or Spanish
- Hans Peyer's advanced workshop with deep injections in English

Neural therapy conferences and workshops:

[Intermediate - Advanced Neural therapy workshop:](#)

Dr. Ralf Oettmeier, Switzerland
Sheraton JFK Airport Hotel, New York
[Nov. 17-19, 2017](#)



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Introductory Neural therapy workshop

David Vinjes MD, Barcelona, Spain
Sheraton JFK Airport Hotel, New York
[Dec. 1-3, 2017](#)

Organized by Dr. Michael Gurevich
Contact: GurevichMD@gmail.com or [516-674-9489](tel:516-674-9489)

Three new articles about neural therapy from Dr. Vinyes' newsletter:

[Injections of Local Anesthetics into the Pharyngeal Region Reduce Trapezius Muscle Tenderness](#)

Stephan Weinschenk, Heidelberg (Germany)

[Efficacy and safety of stellate ganglion block in chronic ulcerative colitis](#)

Hong-Ying Zhao, Cangzhou (China)

[Specificity of Procaine and Ester Hydrolysis by Human, Minipig and Rat Skin and Liver](#)

Christopher Jewel, Michigan (USA)

Sign up at his site <http://www.terapianeural.com/>!



Volume 13, No. 1, Jan 2018

NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of Neural Therapy: Applied Neurophysiology and Other Topics

Dear Colleagues:

This month I would like to take a look at the subject of **Baker's cysts**. These cysts are common and often no more than a nuisance, but **occasionally they become painful**. They may even lead to complications affecting nerve supply and leg circulation creating a situation resembling deep vein thrombosis.

Most Baker cysts develop in the **gastrocnemius-semimembranous bursa of arthritic knees** (rheumatoid or osteoarthritis). They typically contain synovial fluid that is continuous with that of the knee joint space. However **there are other less common causes** and they may even develop in the knees of young children, where no communication exists between the cyst and the knee joint. **For more on unusual presentations, see [this review](#).**

Many cases need no treatment. Often the cysts subside after a year or two. If pain or discomfort develops, the standard treatment is rest, elevation and avoidance of strenuous activity. Compresses are also prescribed at times. Surgery may be resorted to in more severe cases. A [recent report](#) favours arthroscopic excision of the cyst rather than a direct approach.

Does neural therapy have a role in treating Baker's cysts? Probably not in most cases, but there are always exceptions. How about this case?

A 68 year-old woman, a self-described religious "hermit," lived a physically active life in a rural setting, growing her own food, hauling in firewood, carrying water, etc. Over a period of about six months she began to experience "tight cords" in her left posterior knee gradually spreading into her posterior thigh muscles. Prolonged standing made her symptoms worse. She could feel swelling behind her knee, but it was not consistent and changed in size from day to day.

Her knee had a mild chronic valgus and she had a history of knee strains and chronic left foot problems for which she had used orthotics in the past. She had never undergone surgery and there was no history of serious trauma. However she had a mild uterine prolapse for which she used a pessary, but not consistently.

At her first visit, there was no swelling of her knee, posteriorly or anywhere. The knee had a full range of passive extension and about 10 degrees limitation of passive flexion. Because she insisted that there was intermittent swelling behind her knee, and a physiotherapist had said she had a Baker's cyst, an ultrasound was ordered.

The ultrasound report indicated no Baker's cyst and no sign of any other knee pathology - yet there was (on the second visit) a fluctuant posterior-knee swelling, 30 degrees limitation



of passive flexion and no limitation of extension.

Those readers familiar with the late James Cyriax's teaching of joint pathology may remember that arthritic joints, no matter the cause, will have a "**capsular pattern**" of passive motion restriction. **Each joint has its own pattern and for the knee the pattern is restriction of both flexion and extension, but more of flexion.** In the case of my patient there was no limitation of extension at all. Since Baker's cysts develop in association with arthritic knees, what was going on? Did the patient really have an arthritic knee?

*Clearly something unusual was going on. This necessitated a search for interference fields, and yes, **an interference field was found (through autonomic response testing) in the coccyx.** The interference field was treated using the Tenscam device (a procaine injection would have been at least as effective. [See page 192 of my book.](#))*

*A week later the patient returned declaring that the "knee stiffness was greatly reduced". The discomfort in her hamstrings was gone and swelling developed in her posterior knee only after standing more than an hour. An interference field was again present in the coccyx and treated with the Tenscam. **10 days later the knee was asymptomatic and has remained so, with no swelling.***

From my review of the literature and this case, it is clear that **not all Baker's cysts are the same.** My patient's cyst varied in size markedly from day to day. She also had a history of injury to her knee, a slight valgus and recurring ankle and foot problems, all on the same side. The interference field in the coccyx was interesting as there was no history of local injury, but she had pelvic floor problems and needed to use a pessary from time to time. This is probably why **her coccyx, or more likely the pre-coccygeal ganglion, was in a hyper-sympathetic state or had become an interference field.**

New neural therapy research article:

Weinschenk S. et al: Local Anesthetics, Procaine, Lidocaine, and Mepivacaine Show Vasodilatation but No Type 1 Allergy: A Double-Blind, Placebo-Controlled Study.
<https://www.hindawi.com/journals/bmri/2017/9804693/>

Neural therapy workshops

Organized by George Stylian DO, mail to: georgestylian@gmail.com
or 409070504

Integrative Biological Medicine, Neural therapy and Dental injections.
Ralf Oettmeier, MD and Joseph Vizkelety, MD, DDS from Switzerland.



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The Best of Pure Neural Therapy: an exclusive training in NY
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Join this list and become a Founding Member of the North American Academy of Neural Therapy!

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Volume 13, No. 2, Feb 2018

NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

The superior cervical ganglia and the organs directly in front of it (the tonsils) have always been important in neural therapy. By "important", we mean they are common interference fields, and they also have far-reaching effects on the body's health.

The location, anatomy and proximity of these two structures give us some indication of why they are so important. The tonsils are located at the entry points of both the digestive and respiratory systems and play important roles in local and systemic immunity. The lymphoid tissues produce all classes of humoral (Ig) antibodies, and a wide variety of cytokines. That they affect systemic immunity is demonstrated by the observation that the risk of contracting polio during an epidemic tripled following tonsillectomy, especially if the tonsillectomy was recent. (Neural therapists should be intrigued that any sort of surgical procedure including vaccinations increases the risk of polio during an epidemic.)

The tonsils are innervated by the lesser palatine nerves (branches of the maxillary division of the trigeminal) and by the tonsillar branches of the glossopharyngeal nerves. Both sympathetic and parasympathetic nerves are present.

The superior cervical ganglia are arguably the most important autonomic ganglia in the body, located at the cephalad end of the sympathetic chains and involved in many head and neck structures, and in particular circulation to the brain. It is this connection that I want to draw attention to with the following case:

A 73 year-old man presented with episodic weakness and fatigue for the previous three years. He and his wife also noticed that his memory had been "slipping" over the same period of time. The episodes of weakness lasted a few hours. As his father had had Alzheimer's disease, he was concerned about his deteriorating mental function.

Apart from some gastric reflux and a tendency to constipation he was in good health and was taking no medication. Past trauma was limited to a tonsillectomy and adenoidectomy and a cerebral concussion, both in childhood. He had "bad" headaches as a child and had low back ache all his life.

His general medical examination was unremarkable. A structural (osteopathic) examination showed severely restricted craniosacral motion of the temporal and ethmoid bones. Ayurvedic assessment of his radial pulses showed strong pulses in all regions except the Vatta pulse (the left upper third of his body). This indicated that an interference field would be present in the left head, neck or upper trunk. Autonomic response testing showed blocked regulation and an interference field in the left tonsillar area. (Energetic testing for a tonsillar interference field also includes the



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superior sympathetic ganglion - They are too close to differentiate - at least by me.)

From a practical standpoint the classical neural therapy treatment would be injection of a tonsil, followed by injection of the ganglion if the response was not satisfactory. See p.182 of my book. If treated energetically, e.g. by a Tenscam, the difference would not matter. Treatment would include both structures.

Before treating this patient, one noteworthy physical finding stood out. He was a thin man with a long neck and his carotid arteries were plainly visible. However on the left side no pulse could be seen, nor could it be palpated.

Treatment began with an osteopathic release of his cranial base, freeing both temporal bones and the ethmoid. This was followed by energetic treatment of the left tonsillar area. The immediate response was a return of the pulse in the left carotid artery and restoration of autonomic regulation.

Six weeks later the patient reported that he was feeling much better; he had only three "weak spells" and that he was stronger. However on examination his left Vatta pulse was still weak and an interference field could be found in the left tonsillar area. This was again treated with the Tenscam.

At three months he was further improved; he had no further weak spells; his energy had increased and his memory was improved. He was alert and was able to crack a joke. No interference field was found and his carotid pulse was normal.

What I found most interesting in this patient was the clearly visible change in the carotid pulse after treatment. It was not entirely clear if this was the result of the osteopathic treatment of the cranial base (which the carotid artery penetrates) or the treatment of the superior cervical ganglion (and/or tonsil), or perhaps a combination of both. In any case the patient's condition improved but did not clear up entirely until the tonsillar interference field was completely resolved.

Much more could be said about tonsils and their interference fields. However this case was a clear demonstration of its intimate connection with intracranial neurological function.

_____ Letter:

I have seen many Baker cysts in my practice. They are always related to knee dysfunction. And most of the time the knee problems are related to pelvic & tonsil interference fields. Most of the time neural therapy is so amazing to resolve this condition. Sometimes more than one treatment is necessary; and of course don't forget scars.

Carlos Chiriboga
Orthopaedic surgeon & Neural Therapist.
Ecuador



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For neural therapy and advanced healing



Finally!

Dr. Hans Barop's long awaited "Textbook and Manual of Neural Therapy" - translated from the German 2nd edition (2015). This is the most up-to-date and comprehensive textbook on neural therapy in the English language. I will be reviewing this book in a future newsletter.

New neural therapy research article:

Weinschenk S. et al: Local Anesthetics, Procaine, Lidocaine, and Mepivacaine Show Vasodilatation but No Type 1 Allergy: A Double-Blind, Placebo-Controlled Study.

<https://www.hindawi.com/journals/bmri/2017/9804693/>



Volume 13, No. 3, Mar 2018

NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

In a recent newsletter, I announced the release of the long-awaited English translation of **Dr. Hans Barop's neural therapy textbook**. His first edition was published over 20 years ago, and had already become a standard in the German-speaking world. Dr Barop's updated second German edition came in 2015. We are therefore fortunate to have this first English edition in an up-to-date form.

Dr Barop is held in high regard not just as a clinician, but also as an expert in neuroanatomy and neurophysiology. He is in high demand as a speaker internationally and was the lead speaker in the first North American neural therapy conference in Ottawa, last year. Currently Dr. Barop is president of the German neural therapy association.

The book "**Textbook and Atlas of Neural Therapy**" is attractively bound and features the high-quality layout, printing and illustration that we have come to expect from Thieme. It is divided into four sections: (1) History and theory, (2) Practice, (3) Injection techniques and indications, and (4) Indications and therapy. Section (3) is by far the biggest part, at 134 pages of a 292 page book. However **the section that interested me most was section 1**, because of Dr. Barop's reputation as an anatomist and neurophysiologist. The classical neurophysiology on which so much of our understanding of neural therapy depends was well covered, but for me, the best part was **Dr. Barop's explanation of the work of Ricker**(1870-1948), about which I knew little.

Ricker was a researcher of the sympathetic nervous system's control of microcirculation. His work demonstrated that **the cellular pathology described by the mid-19th century Virchow was the functional end-result of sympathetic nervous system disturbance**. This is not news to modern neural therapists, but Ricker in these long-ago experiments showed exactly how this takes place.

Ricker described "**Three Stage Laws**": (1) **Weak stimulus** leading to hyperfusion, (2) **Strong stimulus** leading to hypoperfusion, (3) **Stronger stimulus** leading to change in sympathetic tone towards the periphery. The first two stages are reversible with removal of the stimulus; the third is not and leads to chronic changes - i.e. inflammation and fibrosis. However, Barop points out that **neural therapy can act at this point**.

The five (large) pages that Barop devotes to Richer are **rich with pearls**, e.g. the sympathetic system regulates blood flow by both constricting and dilating vessels using both noradrenaline and acetyl choline. Another one: pathological changes are dependent on blood flow rate - hyperaemia does not mean better supply of the tissues.

Many of these pearls explain phenomena that we see every day in our practices. It



should come as no surprise that **Barop refers to Ricker's work frequently in his clinical material.**

Barop also brings us **up-to-date** in modern **neuroanatomy and neurophysiology**. Some more pearls: "...the pain of cholecystitis or gastritis is transmitted by the sympathetic nervous system, while malaise, nausea and vomiting proceed via the parasympathetic afferents." "...a significant proportion of interference fields can be found in the innervation area of the trigeminal and vagus nerves...and it is crucial to consider the full innervation of an interference field." He goes on to point out the connections between the trigeminal, facial, glossopharyngeal, accessory and vagus nerves as well and sensory and motor nerves in the upper neck. **No wonder so many of these interference fields translate into neck pain, headaches, low back pain** etc.

I liked the way the book was laid out with clear delineation of sections and bolded "notes", many of them of clinical import. **A quick reading of just these notes would be a profitable way of introducing oneself to the book.**

My one criticism of the book is the translation and editing. It is spotty, with some smooth and easy reading, but other areas translated in a cumbersome way with paragraph-long sentences and seemingly unending dependent clauses. There are also some words and terms ("switching" meaning synapsing) awkward to an English-speaker's ear: "This is how the autonomic functional area regulates itself in pure autonomic connectivity. The purely autonomic self-regulation is relativized where there are neural connections to the somatic nervous system." Perhaps I am not alone in finding this hard reading!

Overall however, **this an essential book for any neural therapist.** It is beautifully laid out, is rich in scientific and clinical material, and comes from an experienced and reliable source.

It is an expensive book (\$184.99 US), but reasonable when considering its size, high quality, and numerous coloured illustrations. **It serves as a textbook and as a manual**, and therefore compares favourably with the older Dosch textbook (\$168.09) and the companion injection manual (\$123 - \$156? - on amazon). Available at Thieme.

Letter:

Great case Robert.

I assume the energetic treatment first time with the tonsil was TENS CAM. If this is not available, would you inject with procaine?

Brian Shames MD
Sault Ste. Marie
Canada

Hi Brian,

Yes, of course, procaine is actually the gold standard for neural therapy and I would never say that energetic methods such as the Tenscam are better. I only mention the Tenscam in



*Dr. Robert F Kidd, MD newsletter archive
For neural therapy and advanced healing*



these newsletters because that is actually how I do it.

As you know, I have been using it for many years and I am confident my results are just as good with the Tenscam as with procaine. However energetics are very much affected by the therapist and I know some who have been unable to get any results with the Tenscam. So the jury is still out about the Tenscam. I am hoping that as the years go by, others will surface with their experiences. The Tenscam does not lend itself to comparison studies because every case is different.

Best wishes,

Robert

Thanks Robert

When I use TENS CAM after any block, it magnifies the block effect quite a bit. I have to be careful with anaesthetic side effects due to this.

Brian

New neural therapy-related research article:

[Resolving bulimia using neural therapy](#) Gurevich M., Chung Mk, La Riccia P

[Trigger point injections for renal colic](#) Iguchi M. et al

[The effectiveness of neural therapy in Bell's Palsy](#) Yavuz F., Kelle B., Balaban B.

(With thanks to Dr. David Vinje at <http://terapianeural.com>).

Neural therapy workshops:

Integrative Biological Medicine, Neural therapy and Dental injections.
Ralf Oettmeier, MD and Joseph Vizkelety, MD, DDS from Switzerland.

The Best of Pure Neural Therapy: an exclusive training in NY
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For more information: [HolisticMD.org](https://www.holisticmd.org); Contact: GurevichMD@gmail.com or 516-674-9489

"**The North American Academy of Neural Therapy** now has a mailing list. If you'd like to be kept in the loop about what the NAANT is up to, **please sign-up** at <https://www.naant.org>."

Three new Founding Members!

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Volume 13, No. 4, Apr 2018

NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

One of my pet peeves in medicine is **pseudo-diagnosis - labelling a condition with a name suggesting knowledge that does not exist**. "Arthritis of the spine" comes to mind, used for non-specific backache associated with disc degeneration on x-ray. This is a standard "out" for physicians who don't have a clue as to what is causing the patient's backache, but feel they have to tell the patient something.

The suffix -itis is similarly misused. **Attaching "itis" to the name of a painful organ or structure implies that inflammation is present** even when calor, rubor, or tumor is not. All we have is *dolor* - but not enough to justify the "itis" suffix. I have already written about pseudo-diagnosis of this kind in the case of [trochanteric "bursitis"](#) (Vol. 7, No. 2) now more properly called "greater trochanteric pain syndrome".

A similar situation occurs with "**plantar fasciitis**", that common condition of pain in the posterior sole of the foot - dolor, but no calor, rubor or tumor - at least at a macroscopic level. However I was surprised to find on a PubMed search considerable literature on the subject. And yes, **there is objective evidence of something going on in the fascia but it is not inflammation**. [Histological studies](#) have shown that the condition is a **degenerative process**, which means that steroid injections and/or anti-inflammatory medication are not indicated. Ultrasound and MRI demonstrate a thickening of the fascia confirming what is a relatively simple clinical diagnosis: pain on taking the first few steps in the morning, and after prolonged standing; tenderness at the plantar-medial aspect of the heel; and pain on passive dorsiflexion of the ankle and toes.

Plantar fasciitis is most common in middle age, in the obese, in runners and those spending much of their time on their feet. Almost twice as many women are affected as men. In one study, [45% of patients had pain persisting at 15 years from onset](#). And up to 50% have bilateral symptoms. **The pathophysiology is felt to be one of repetitive strain and micro-tears**.

Most treatment has been directed at the plantar fascia itself, with corticosteroid injections, [plasma rich platelet injections](#), [extra-corporeal shock wave therapy](#), [prosthetics and orthotics](#), [taping and other conservative measures](#) showing minimal benefits. [Osteopathic manipulative treatment of the foot may provide short-term relief](#), but no evidence exists of a lasting effect. However I could find nothing about the use of more general osteopathic treatment (at least in PubMed and "Foundations for Osteopathic Medicine"). And plantar fasciitis is not mentioned in the Dosch or Barop neural therapy textbooks.

It is a little known fact that **pain can be referred to the underside of the heel from the**



sacroteruberous ligament. Hackett demonstrated this in his studies of pelvic ring ligament referral patterns*. Because referred pain is often also tender, this scenario can easily be misdiagnosed as "plantar fasciitis". Correction of pelvic ring imbalance with manipulative treatment, or perhaps prolotherapy, can relieve this type of heel pain. In my practice, heel pain from the sacrotuberous ligament is not rare.

Recently however, I came across a case of plantar fasciitis that fit none of the above categories. *A relatively healthy 64 year old man presented with a variety of complaints including psoriasis for 15 years, gastrointestinal reflux for 40 years, a myocardial infarction two years previously and **left plantar fasciitis** of about two years duration. Past trauma included a fractured right forearm requiring orthopaedic surgery in his teens, **a right inguinal hernia repair** at age 59 and several root-canalled teeth*

*I obtained a complete history and examined the man thoroughly, but decided to concentrate on a few physical findings that potentially related to the plantar fasciitis. His **left hamstrings were tighter than his right, the left pube was a few millimetres inferior to the right** (while supine) and the **left sacroiliac joint was looser than the right** - while prone, gentle cephalad pressure on the left side met less resistance than the same maneuver on the right. (I call this an "innominate upslide" - similar to an "innominate upslip" except that the ischial tuberosities are level and the sacroiliac joints are motion-tested. See ["The Innominate Upslide sign..."](#))*

*Autonomic response testing indicated **an interference field in the medial half of the hernia scar**. This was **treated using the Tenscam device** (an alternative treatment would have been infiltration with dilute procaine) and the pelvic ring assymetry returned immediately to normal. **Four weeks later the man reported that his plantar fasciitis was 60% better; at two months it was almost normal.***

I suspect that in this case **the heel pain was referred from the sacrotuberous ligament that had been under strain from the pelvic ring imbalance**. This mechanical imbalance was in turn a result of an interference field in the inguinal hernia scar.

The "take-home" lessons here are: beware of the suffix "-itis". Not all pain and tenderness is due to inflammation. And even if inflammation is present, we should not stop there. Let us find out the cause and treat it. **It could be due to an interference field!**

*Ligament and tendon relaxation treated by prolotherapy, Hackett GS, Hemwall GA, Montgomery GA. (1991) 5th ed. P.29



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

Migraine would seem to be a happy hunting ground for neural therapists. After all, among its most distinctive features are the **autonomic nervous system** disturbances that go with it. With some categories of migraine, they are the only symptoms.

Migraine comes in many forms. The International Classification of Headache Disorders list 29 subcategories, including many that do not include headache at all. The most common variants are *migraine without aura (common migraine)* and *migraine with aura*. Both of these groups have many subcategories.

Migraines are classified entirely by symptoms. Moreover, a defining characteristic of migraine is that there are no symptoms between attacks. Most of the time **the symptoms indicate the parts of the brain that are affected**, e.g. *familial and sporadic hemiplegic migraine, retinal migraine, cluster headache, vestibular migraine etc.*

An interesting kind of migraine is **abdominal migraine** diagnosed mostly in children. Physicians easily miss it, and the onset of attacks can be **similar to the onset of acute appendicitis** - loss of appetite, central abdominal pain, vomiting, etc. **The key to diagnosis is its cyclical pattern with complete normalcy between attacks.**

I was referred a case recently to my office, by an astute family physician who made the diagnosis after others had not. Here is the story:

*A 12 year- old boy was brought by his mother for consultation because of **recurring attacks of abdominal pain** - several times a day for the previous three weeks. Each episode lasted a few minutes. There was no radiation of pain or nausea or vomiting, but the pain was severe enough that he had been taken by ambulance to the Emergency Department. Later his family physician diagnosed "abdominal migraine" and prescribed propranolol. This had the effect of the pain moving superiorly to the chest and neck.*

*He had a "**sensitive stomach**" since infancy and three years previously had a similar series of attacks, with no diagnosis being made. Four or five bowel movements a day were normal for him.*

*On examination he was a healthy-looking, although overweight boy in no distress. (He had almost doubled his weight - to 165 pounds - in the previous three years.) His hamstring muscles were tight, suggesting **magnesium deficiency** and his fingernails displayed leukonychia, indicating **zinc deficiency**. These findings combined with **chronic gastrointestinal sensitivity** and a large **unexplained weight-gain** made a diagnosis of gluten*



Dr. Robert F Kidd, MD newsletter archive
For neural therapy and advanced healing



sensitivity highly likely.

Autonomic response testing revealed an **interference field in the coeliac plexus**. This was treated with a Tenscam device. (A classic neural therapy injection of procaine 1/2% would have been equally effective. This easy and safe injection is described in [my book](#) on page 187.)

Two days later he had a bad headache, and on day 3 a mild attack of abdominal pain. He required no further treatment and had **no more attacks in the following five months**. He was prescribed a gluten-free diet to prevent recurrence.

In many ways **the pathogenesis of migraine continues to be a mystery**. Autonomic, sensory, cognitive, emotional and motor function can be affected and many parts of the brain may be involved. Autonomic nervous system function has attracted the most research interest, but few clear-cut answers have emerged [An imbalance between sympathetic and parasympathetic tone](#) is frequently observed. All four phases of migraine (premonitory, aura, headache and postdrome) appear to be affected and some studies show autonomic dysfunction even between attacks.

For the most part **autonomic dysfunction is assumed on clinical grounds** with the presence of nausea, vomiting, diarrhea, polyuria, eyelid edema, conjunctival injection, lacrimation, nasal congestion, and/or ptosis. [Cranial parasympathetic symptoms](#) are common, but overall [sympathetic impairment is dominant](#) and can be detected even during the interictal period.

We know there are many potential triggers of migraine, including certain foods, weather changes, stress levels, hormonal fluctuations, sensory overstimulation, over-exercise, head trauma etc. The potential for migraine is inherited in an autosomal dominant manner.

So where does neural therapy come in? Migraine is a syndrome, and syndromes can be triggered by what Speransky would call a "**second blow**", i.e. an irritation of the nervous system anywhere in the body that re-awakens an existing "tissue memory". Experienced neural therapists look for scars, dental problems and other nervous system irritations that may have initiated or maintained a propensity for migraine headaches. Osteopaths look for somatic dysfunction anywhere in the body. In my experience somatic dysfunction is probably a more common irritation than scars or troublesome teeth, especially somatic dysfunction of the cranium.

In my young patient's case, **the irritant was the coeliac plexus**. Interference fields in the coeliac plexus usually develop from chronic or intense irritation of both the upper and lower gut - "both" being the operative word. In his case it was probably a relatively silent reaction to dietary gluten - an allergen that can affect any part or all of the gut.



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Letter to the editor:

Dear Dr Kidd:

With regard to objective methods to find/document 'interference fields', do you know if anyone has investigated thermography? Despite the shortcomings of thermographic analysis, thermography shows physiologic alterations, especially those of microcirculation. It would be fascinating to have a thermographic image of a interference field producing scar before and after neural therapy (it could potentially also document effectiveness of TENS/CAM as well). I have a simple thermographic camera, and will do some basic studies, and will let you know if I find anything worth pursuing.

Theodore Jordan, DO
Ohio, USA



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

This month I want to report on the **progress of the North American Academy of Neural Therapy (NAANT) in creating an educational program**. This is not an easy project as it requires consensus on what neural therapy is, and that is not always clear.

Every physician who incorporates neural therapy into his or her practice does so in a particular way. This will be individual and depends on his or her training, past experience and outlook. What is true for each individual is also true of whole medical traditions and thus we have differences in how neural therapy is practiced in Europe, (even parts of Europe), North and South America.

These differences are not bad; in fact they can enrich the body of neural therapy, and open eyes to new possibilities. Hence the value of international conferences.

However, in developing an educational program, **some consistency is needed**, if only to prevent redundancies. Practically speaking, a physician seeking education in neural therapy **needs to know if he or she will be learning something new** when enrolling in a new course.

North American neural therapy education to the present has been piece-meal, offered by various physicians, beginning with Dietrich Klinghardt in the 1980s, and invited teachers from Europe and South America. The only other source of teaching in the English language is the [Heidelberg program](#), but only a handful of North Americans have taken advantage of this.

The NAANT board (which includes me) has been considering various possibilities in developing an educational program. **Existing programs in Europe and South America have been evaluated**, but in the end, it was decided that we need a "**made in North America**" solution. Our priority has been to create something that takes into account the economic and time constraints of busy North American physicians. (A rapidly changing medical-legal-economic climate is putting enormous pressure on those few physicians still in private practice.)

In other words, our goal is to produce **an introductory neural therapy course that will equip the student to practice at least some neural therapy right away**. We are assuming most of those interested will be experienced physicians for whom the technical aspects of injecting will be a matter of course, at least for the beginning levels. The goal then will be to present a "**new way of thinking**", **the ideas, and the basic science that makes neural therapy come alive**.



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For neural therapy and advanced healing



We also want to present **something new by integrating some of the advances coming out of the New World**, e.g. the understanding of non-linear dynamics in neural therapy by Beltran, Pinilla and Koval in South America, the osteopathic concept of somatic dysfunction as an interference field, the use of energetics in diagnosis, etc. into the body of neural therapy that emanates from Europe.

On June 9th, the executive of NAANT met in Chicago for a day-long discussion of this project. Out of this came a consensus of what will be taught and how it will be taught in an introductory two-day course. The plan is this: **The lecture part of the course will be divided among five experienced neural therapists.** Why so many? - so that the content can be critiqued by the rest of the faculty and optimized for future courses. Having a large number of teachers will also give the students more individual attention in the practical sessions. We also plan to train a teaching faculty so that future introductory courses will be taught by pairs of instructors in different locations across North America.

Energetic testing (autonomic response testing) for interference fields will be taught early in the course as part of the physical examination. Our reasoning is that busy North American physicians need to be fast-tracked into making **accurate diagnoses quickly**. Neither physicians nor their patients have the time and patience for multiple test injections. (This of course is not to discount the importance of careful history-taking and examination.)

Readers of this newsletter will know that I frequently use energetic methods of treatment in place of procaine injections. However, during this and future courses, injection of procaine will be considered the standard of care, - if only to align ourselves with the standards of our international colleagues and the [Heidelberg Declaration](#).

The first introductory course will be held (tentatively) in Henderson, Nevada at Touro Osteopathic Medical school on November 9th and 10th. The instructors will be Robert Banner MD, Jeff Harris ND, Robert Kidd MD,CM, Bernadette Kohn DO and Perry Perretz

NAANT Website now launched!

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NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

Neural therapy does not come immediately to my mind when patients present with skin problems. If contact dermatitis is not the issue, I usually think of systemic disturbances, especially diet, intestinal parasites, toxic exposures etc.

So when this 76 year-old man presented with a **skin rash on his hands and feet** of two months duration, **associated with increasing fatigue** for the previous two years, I began to look at his general health. He had no other specific complaints but had noticed his weight had increased by five pounds in the preceding months.

His previous history included "dozens" of episodes of renal colic through his adult life, a "basket removal" 25 years previously and lithotripsy three months before. His surgical history was limited to a remote right knee replacement. He also had a history of eczema and psoriasis 30 years previously and had been taking a statin drug and eprosartan (an angiotensin 2 inhibitor) for many years.

His physical examination was unremarkable except for a **scaling erythematous rash of his hands and soles of his feet, and a patchy macular erythema below his nose and on the dorsa of his hands and wrists.**

Because of his fatigue and weight gain, I immediately proceeded to use autonomic response testing **to evaluate his nutritional and hormonal status.** No significant nutritional deficiency of vitamins or minerals was detected, but an autonomic response to the presence of desiccated thyroid suggested **hypothyroidism.** I accordingly ordered a serum TSH, free T3 and free T4 levels and (because of the skin rash) advised short-term discontinuation of his medications.

Five weeks later he returned with no change in his skin condition. His serum TSH was 3.58, free T3=4.5, and free T4=12.0. However while re-examining him I remembered that his skin condition had begun about a month after his lithotripsy. Autonomic response testing indicated **an interference field in his right kidney!**

This was treated using the [Tenscam® device](#). (Quaddles of dilute procaine into the skin over the kidney would have achieved the same result.) Because of his borderline hypothyroidism, I also prescribed a commercial "Thyroid Support" (supplementation of selenium, iodine and various herbs).

Six weeks later his skin rash had almost completely disappeared and no sign of an interference field in the kidney could be found. He felt more energetic, so we decided to continue with the thyroid support and re-test the thyroid blood parameters in six weeks



time.

To our surprise, the TSH actually increased to 7.72, so clearly a thyroid problem had emerged. However there was no recurrence of the skin rash nor the kidney interference field. So clearly the low-functioning thyroid was a "red herring" and had nothing to do with the skin rash.

Skin rashes caused by interference fields are rare in my experience, with one exception. That is **urticaria, sometimes associated with an interference field in the small intestine**. When this is found, **intestinal parasites** are usually present and their treatment with medication or herbs resolves the problem. (Neural therapy by itself is unlikely to provide lasting benefit.)

Autonomic response testing (See [page 42 of my book](#)) will identify the small intestine interference field; the response should then be challenged with the presence of anti-parasitic medications i.e. if the weak muscle goes strong in the presence of **mebendazole**, that is the medication to prescribe. Other anti-parasitics that I use for testing are **ivermectin** and praziquantel or herbs like artimesia and cloves.

Intestinal parasites [are not on the list of causes of urticaria](#) of the American Academy of Dermatology, but in my experience is commonly the culprit in "idiopathic" cases. Since **the small intestine is the largest immune organ in the body**, it stands to reason that it might be involved in unexplained allergy.

However, as in my patient's case, **interference fields from almost anywhere can trigger an immune response** and should be considered especially when symptoms begin in the month or two after a traumatic event.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

One of the best indications that neural therapy may be the solution to our patient's pain problem is **failure of manual treatments to help a situation that is clearly mechanical in nature**. This is especially evident when chronic pain develops after a traumatic event and skilled manual treatment gives no lasting relief.

My patient, (a 42 year old female) developed **neckache** not long after a front-end motor vehicle collision two years before her appointment. **The pain had responded poorly to chiropractic manipulation and massage**, and in fact **headaches** had begun in the five months preceding her visit. The neck pain centered in the right upper posterior cervical region and the headache was felt in the right occiput and right forehead. Activity provoked pain in the right interscapular area. Clicking was experienced in the right temporomandibular area, but this symptom had been present even before the accident.

The patient otherwise had an uncomplicated medical history. Her wisdom teeth had been extracted in her teens and she had undergone a hysterectomy at age 26 for menorrhagia. There was no other history of trauma. However, she had noticed some **decline in her energy over the previous year and attributed this to mould exposure** in her workplace, as she felt better on the weekends.

On examination there was a restriction of rotation of the head to the right and a palpable area of localized muscle spasm about 3 cm in diameter just to the right of the C2 and C3 vertebrae. The right temporal bone was externally rotated. **All three Ayurvedic pulses**(See vol.6, no.2 of [my newsletters](#)) **on the right side were very weak**, indicating an important interference field somewhere on the right side of the body. In addition, a **"therapy localization sign" was present on the right side** ([see page 51 of my book](#)). Deep tendon reflexes throughout the body were symmetric and quite brisk.

The above signs were highly suggestive of an interference field in the head or neck region and a careful search was made using autonomic response testing (See chapter 4 of [my book](#).) The wisdom teeth scars, tonsils and teeth were checked, as well as the cervical sympathetic ganglia (because of the whiplash injury). Nothing was found until the cranial autonomic ganglia were tested. **An interference field was detected in the right submandibular ganglion** and it matched the therapy localization sign - a strong indicator that this was the interference field. This was puzzling as submandibular ganglia interference fields are usually associated with dental problems.

Treatment with a Tenscam device, (an alternative would have been to inject 3 ml. procaine 1/2% - see [page 183 of my book](#)) resulted in abolition of the interference field, but no change in the blocked regulation. This indicated that there was still "unfinished business". A further



search indicated **an interference field in the right sphenopalatine ganglion**. This was also a puzzle because sphenopalatine ganglia usually become "activated" with dental or facial sinus problems. However, it crossed my mind that the patient's **sphenopalatine ganglion interference field might have something to do with the patient's fatigue and reaction to mould in her workplace**. (The brisk tendon reflexes might also have been caused by the mould's neurotoxic effects.) A specimen of mould was then introduced into her field, and the autonomic response (indicator muscle weakening) reversed, supporting the idea that mould was at least part of the reason for this up-regulation of her nervous system. The sphenopalatine ganglion was then treated with the Tenscam device and open regulation resulted. The patient was discharged with advice to reduce her exposure to mould.

Three weeks later the patient reported that her headaches were "less severe". Re-examination revealed again an interference field in the right submandibular ganglion, this time associated with **an interference field in tooth 4.7** (second right lower molar). Using dental homeopathics, it became apparent there was an occult infection in or near the tooth. This was treated using the ultraviolet frequency of the Tenscam device; the interference field disappeared, and regulation was again achieved.

On the next visit one week later, **the headaches and neckache had disappeared entirely**, but tooth 4.7 needed one final treatment to achieve open regulation. Two weeks later the patient presented with no neckache or headache, no interference fields, and open regulation.

This case was interesting for a number of reasons: **(1) the non-mechanical factors preventing resolution of a seemingly mechanical injury; (2) the (at first) completely hidden dental interference field; (3) and the contribution of an environmental factor (the mould)**. (Mould is a neurotoxin in some people and can have similar effects on the nervous system as have toxic metals, gluten, organic solvents and other toxins.)

NAANT Website now launched!

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LETTERS:

Dear Dr. Kidd,

I was inspired to share a 'skin patient' with you based on your most recent Newsletter.

I have a 40 year old female patient who had been experiencing ongoing skin issues for over a year - the diagnosis was folliculitis. I traced back the onset to around the time of a dog bite



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on the woman's thigh. We treated the scar with neural therapy. I didn't see the patient for over a year, never knowing the outcome of the treatment. I just saw her last month and she stated that after the treatment her skin issues resolved and she has been touting the excellence of my care ever since. Teaches me that following up is so important to know how effective or ineffective our treatments are.

Thank-you for sharing your passion for neural therapy.

Dr. Jennifer Moss,
Squamish, BC
Canada



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

Long-time readers may remember that six years ago I wrote a newsletter on **the subject of hip pain** and how usually the problem is not in the hip. When the only physical finding is tenderness, it is often **misdiagnosed as trochanteric bursitis**. However, this term has fallen into disrepute as little evidence exists to support the presumed pathology.

In fact, hip pain is usually referred from somewhere else, commonly the iliolumbar ligament or a quadratus lumborum muscle trigger point. This month I would like to explore other presentations of hip pain, i.e. **bilateral hip pain** and **pain presenting on the opposite side to the lesion**. And perhaps draw out some principles that apply to other pain syndromes that lateralize or present on both sides.

Whenever pain presents in a specific location the clinician needs to determine if the pain is caused by something locally, or if it is referred from somewhere else. When clear-cut physical findings are present, e.g. local swelling or restricted range of motion of a knee joint, chances are high that the pain is coming from the joint itself.

However, if the problem presents on both sides of the body, e.g. bilateral plantar fasciitis, **my reasoning is that a local pathology is highly unlikely to present in two similar places on opposite sides of the body at the same time**. There must be something central or systemic underlying such a presentation. This likely holds true for a similar problem occurring on the opposite side of the body at different times. (The one exception is the "cross-over phenomenon" where signs and symptoms associated with an interference field can be mimicked on the opposite side of the body. See page 13 of [my book](#).)

Bilateral hip pain is not a rare phenomenon. These people often say that they cannot sleep on either side. I believe that the reason bilateral hip pain is common is that there are **so many potential midline interference fields**. Perhaps the most frequent ones are the **coccyx and the prostate, but bilateral hip pain can come from the anus, pelvic floor scars, the pubic symphysis, the urinary bladder or any midline abdominal surgical scar**. Somatic dysfunction of the pelvic ring or lower lumbar spine can aggravate the situation.

Other bilateral pain syndromes include (at times) carpal tunnel syndrome. In addition to metabolic causes (hypothyroidism, hormone imbalances, inflammatory conditions) attention should be directed at the upper thoracic spine and especially the cervico-thoracic junction.

Unilateral pain can also be a puzzle, if the search for causes is limited to the same side. When I was first introduced to osteopathy 35 years ago from a MD background, I realized that osteopathy and conventional medicine had different approaches to diagnosing



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musculoskeletal pain. MDs were trained to start with the symptom and then search for the anatomical cause. DOs were trained to look for somatic dysfunction; the connection would be made by treatment which would usually correct the symptom wherever it had manifested.

These parallel approaches to diagnosis lead me to embark on a study of the symptoms associated with a common, but very significant somatic dysfunction - an "innominate upslip" or a "superior innominate shear" (a superior displacement of the innominate bone relative to the sacrum at the sacroiliac joint). I simply recorded the location of the patient's pain and whether the pain disappeared when the somatic dysfunction was corrected.

I was not surprised to find **innominate upslips were associated with pain in many parts of the body (e.g. head, neck, or chest) and not just the low back or leg. However, what was unexpected was that the pain was close to 50% ipsilateral and 50% contralateral** at whatever level the pain presented. I published [two studies](#) of this phenomenon in the now defunct journal Manual Medicine (total of 125 patients) and although they are still referenced in the literature, I am not aware of any similar studies since.

Another common location of pain presenting on the opposite side to the lesion is **anterior knee pain associated with tight hip adductor muscles** and often asymmetry of the pubic bones (one slightly superior to the other). Knee pain of this nature is easily corrected by manipulation with the goal of releasing the tight hip adductor muscles. I have no data on this, but I find **tight hip adductor muscles very commonly on the opposite side to that of the painful knee.**

Many of the examples given above are osteopathic in nature and require some knowledge of manipulation to treat. However **most somatic dysfunction can also be treated with procaine injections.** If the tight muscles are identified, e.g. tight hip adductors, the neural therapy treatment is simply injection of procaine ½% as quaddles into the overlying skin. This technique, called "**segmental therapy**" will immediately relax the tight muscles. (See pp. 57-58 of [my book](#).)

New **neural therapy articles** (courtesy of David Vinjes at <http://www.terapianeural.com/>):

Molnar I, Szoke H, Hegvi G. [Effects of neural therapy in patients with Raynaud Syndrome](#). European journal of integrative medicine 18 (2018) 59-65.

Weinschenk et al. [Reliability of reflex points in chronic neck pain](#). Published online in 2016.



NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

This month I would like to discuss the relationships between **neural therapy and surgery**. We all know to look for scars, but there is much more that can happen in surgery than the creation of scar interference fields.

In fact, **surgery is always a traumatic event**, physically and emotionally. The body will always react in a protective way and **the sympathetic nervous system is called into action in its defense**. It is when healing is well under way, but the sympathetic nervous system reaction persists, that interference fields develop.

Emotion plays a big role, which is why emotionally-charged surgeries are the most likely to leave interference fields. Surgery for breast cancer is far more of an emotional event than breast plastic surgery (reduction or augmentation) when the patient is in a positive, optimistic state of mind.

So, in what other ways is the body traumatized in surgery? Certainly, **organs can be traumatized** and become interference fields themselves. Even part of an organ can be traumatized. Recently, a 63-year female patient presented with constipation after minor bowel surgery (polypectomy while undergoing colonoscopy). **Her interference field was in the descending colon alone** (as diagnosed by autonomic response testing) and she responded very well to one session of neural therapy (Tenscam device, although quaddles of procaine into the overlying skin would have worked as well.)

One of the most intriguing phenomena is that of **interference fields in the location of organs that have been surgically removed**. The best example is the gall bladder, where over 30% of patients have persisting gall bladder pain after surgery ("[post-cholecystectomy syndrome](#)"). **Appendectomy** can have the same result - persisting right lower quadrant pain lasting even decades. These syndromes resemble phantom limb pain and are only partly explained in neurophysiological terms. I personally feel that the best answers lie in the emerging field of energetics, where the body's "field" is semi-independent of the physical body. (Think of the salamander re-growing an amputated limb of perfect shape and length.)

Whatever the explanation, neural therapy injections into the skin in the same pattern as if the organ were still there, often gives lasting relief.

During surgery, there is often ancillary trauma from skin penetration for secondary reasons. If the patient's symptoms began a few weeks after surgery, we need to consider **drainage tube scars, spinal tap needle punctures, and scars related to blood vessel access - arterial and venous lines, subclavian taps, intravenous "cut-downs", etc.** The size of the



scar has nothing to do with the strength of the reaction, so everything should be checked.

Speaking of the size of scars, **when I first learned neural therapy, I was taught to be meticulous in injecting scars:** inject the whole scar; inject deep as well as superficial; make sure every stitch scar is treated, etc. With the advent of autonomic response testing we learned that this is not necessary. In fact, often only a small part of a scar is an interference field. This can be particularly helpful to know with massive chest scars where huge amounts of procaine would be necessary to cover all scar tissue.

What other trauma can our patients encounter with surgery? Nasal intubation sometimes leaves memories of trauma in the nasopharyngeal area. The nose, facial sinuses and sphenopalatine ganglia are possible locations of interference fields. Unconscious patients can be mishandled when transferred from operating tables, to stretchers, to beds, etc. Somatic dysfunction of the pelvis (an osteopathic form of interference field) can be the result and should be checked for, especially with musculoskeletal pain.

And lastly, let us consider chemical (or **pharmacological trauma**) from general **anaesthesia**. A recent case of a 49 year old woman presented with severe nausea and gastrointestinal reflux starting a few days after abdominal surgery. The surgery was resection of a large ovarian tumour, which (because her menses had stopped a few months previously) I had first suspected was a pregnant uterus!

An interference field was found (by autonomic response testing) in her liver and was treated using the Tenscam device. Four days later she reported a 50% improvement in her symptoms, but only for a day. A repeat examination showed a return of her liver interference field and again using autonomic response testing **a reversal of her response in the presence of DMSO** (the "universal solvent" - see Chapter 10 of [my book](#)). **There was also a response to liposomal glutathione**, indicating her stage 2 liver detoxification needed assistance.

The liver interference field was again treated and the patient was prescribed oral liposomal glutathione. Six weeks later she returned symptom-free, reporting that "the liposomal glutathione helped a lot!".

The liver is asked to do a lot during general anaesthesia and as is becoming increasingly apparent in functional medicine, **patients have varying degrees of ability to detoxify**. It should not be surprising then that some patients will decompensate during general anaesthesia and will need neural therapy and supportive care to recover.

Interesting paper from Belgium:

Dear Dr.Kidd,

Here is a link to our paper:

<http://publicationslist.org/data/jacques.beco/ref-78/Beco2018-NPT-Acupunture.pdf>



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Dr Stan Antolak in Minneapolis tried local anesthetics and obtained the same results but the patients had numbness in the median nerve territory.
D5W has no side effect and is very effective in this indication and in many cases of neuralgia.

Best wishes,
Jacques Beco



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NEURAL THERAPY IN PRACTICE

An e-newsletter from Robert F. Kidd, MD, CM

Author of *Neural Therapy: Applied Neurophysiology and Other Topics*

Dear Colleagues:

This month I would like to discuss **dental infections, and what to do about them.** Everyone familiar with neural therapy knows how important teeth are in finding the causes of unexplained illness. In fact, after scars, dental interference fields are the most characteristic feature of neural therapy. Neural therapy appears to be the only medical system that takes dental problems into account.

Teeth are important for various reasons. Their neuroanatomy is complex and connects intimately with the upper cervical spine and the brain stem. (**Dr. Barop's outline of the anatomy and neurophysiology is highly recommended:** pp.144-145 of [Textbook and atlas of neural therapy.](#)) In addition the teeth are closely connected to the body's energetic system. See 81-83 of [my book](#) and chapter 7 of the book for an overview of the whole subject of "**Dental aspects of neural therapy**".

What I would like to discuss in this newsletter is how to evaluate dental interference fields and options for treating them. In my experience, **most dental interference fields harbour infection.** Many or most of them are asymptomatic and only some of them show visible inflammation of the adjacent mucosa.

How can we know infection is present? Xrays can be helpful as well as the standard methods of dental examination - palpation, checking tooth vitality, etc. However, **the most sensitive tool is autonomic response testing.** In fact, there is probably not another place in neural therapy where autonomic response testing has more value.

The technique is simple. The strength of an indicator muscle (usually the patient's right shoulder flexors) is evaluated as a baseline. Then **the physician touches the suspect tooth, looking for a weakening in the indicator muscle.** Both buccal and lingual sides should be tested, as it is not unusual to find only one side affected. Adjacent teeth should be tested as well. There should be a clear difference in indicator muscle strength between the suspect tooth and its neighbours.

Once a dental interference field has been detected, **the next step is to determine if it is infected** and if so, with what organisms. Here a kit of dental homeopathics or isopathics is needed. (Unfortunately, the excellent nosodes produced by Staufen Pharma are no longer available as the company went into receivership in 2015. The big advantage of these was the nosodes for mercaptanum and thioether, both toxins found in toxic root canal teeth. Some of you may still have these and I would encourage you to use them as they have the advantage of indicating how toxic the tooth is.)

The next best choice is isopathics, i.e. the Sanum remedies, - Notakehl, Mucokehl and



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Pefrakehl. (readily available through various suppliers in North America and Europe) These are not strictly speaking homeopathics, but they work energetically nevertheless. **If autonomic response testing matches one or more of these isopathics**, one can be sure that firstly, there is an infection, and secondly that the infection will respond to that isopathic.

The technique is this: When a dental interference field is detected through autonomic response testing the homeopathic or isopathic is placed near or on the patient. **If the weak muscle then becomes strong we know there is a "resonance" between the dental infection and that particular remedy.** If no resonance is detected, there is probably no infection and the interference field can be treated with standard local anaesthetics in the usual way.

If a resonance is found, the dental infection **can still be treated with a simple local anaesthetic injection, but the response will be much better if mixed (50%) with the appropriate homeopathic or isopathic.** The patient should then be instructed for re-evaluation and repeat injection about twice a week. Nearly all respond within three weeks.

The above method will work on uncomplicated dental infections and also on root-canal teeth, even with peri-apical abscesses. However, I feel it important that **the patient's general health be taken into account when deciding on treatment.** If the patient has a serious disease, e.g. a cancer or an autoimmune disease, the tooth should probably be extracted and the dental space carefully debrided. If there are many amalgam-restored teeth in the mouth, the patient needs to be checked for mercury toxicity or sensitivity to mercury. Consultation with a biological dentist would be wise for teeth that are crowded or displaced in unusual positions.

As a rule of thumb, I feel root canal procedures should be avoided, except in certain circumstances. If a tooth is an important one, e.g. a first molar and the patient is healthy and has strong genetics, there may be a case for making an exception to this rule. This is a controversial subject even among experienced biological dentists.

One final note: **Infected teeth can also be treated effectively using energetic devices.** As old-time readers know, I use the Tenscam® device, often in conjunction with matching homeopathics or isopathics. The technique is to hold the vial over the tooth and direct the energy through the vial for about 45 seconds. Treatments generally need to be repeated in the same way as if the tooth had been injected. An even more powerful energetic treatment is the Lasercam® that has within its signal a small band of the ultraviolet spectrum that is bactericidal for many dental pathogens. My experience is that it reduces the number of return visits until the tooth has settled down.

I hope this information will be helpful to those wanting to get into this fascinating area of neural therapy. **Neural therapy works by optimizing the body's immune system, but there are times when neural therapy alone needs some help from outside the field.**

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